Policy

G-2100 RETROACTIVE REIMBURSEMENT

The BLANCHARD, ET AL V. FORREST court judgment requires the agency to reimburse *the* Medicaid *enrollee* certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through receipt of the initial **M**edical **E**ligibility **C**ard **(MEC).**

To qualify for reimbursement, the following criteria must be met:

1) The *enrollee* was Medicaid eligible for the date of service.

2) The agency has verified that the provider was an enrolled Medicaid provider on the date the *enrollee* received service.

3) The bills must be for the period beginning three months prior to the month of application through receipt of the initial MEC or reactivation of the MEC. Reactivation of the MEC would take place when an *enrollee* of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program, the certification period is usually twelve months.

4) The *enrollee* has not received reimbursement from Medicaid, the Medicaid provider or received payment in full by a third party entity.

5) The medical bills must be for medical care, services or supplies covered by the program at the time the service was delivered.

6) The *enrollee* must provide proof of payment to BHSF. Bills which were paid in full by a third party (such as Medicare, an insurance company, charitable organization, family or friend) cannot be considered for reimbursement unless the *enrollee* remains liable to the third party. It is a requirement that continuing liability of *the enrollee* be verified.

G-2100 Continued

Bills Not Eligible for Reimbursement

- Unpaid bills – refer the *enrollee* to the service provider with instructions to present the MEC to the provider for billing purposes.
- Bills paid by the *enrollee* after receipt of the initial MEC or reactivation of the MEC.
- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.

The local office shall issue BHSF Form 1-RRP which is a part of the decision notice for all *enrollees* determined eligible for a period prior *upon* issuance of the initial MEC or reactivation of the MEC. The *enrollee* is given 30 days to contact Medicaid to request consideration for reimbursement.

Effective 6/6/05, the MMIS Retroactive Reimbursement Unit is responsible for processing retroactive reimbursement requests. Field staff should refer all retroactive reimbursement requests to the MMIS Retroactive Reimbursement Unit for processing. The following procedure should be followed:

- Scan and file all documentation directly into the financial eligibility case record; and
- Send an e-mail to the MMIS Claims Processing/Recipient Reimbursement Unit at medrrp@dhh.la.gov letting them know that there is a new request in the financial eligibility case record. The case name and social security number should be included for identification purposes.

Note: If information is scanned into ECR and an e-mail is sent to medrrp@dhh.la.gov, do not send a duplicate "hard copy" through the mail.

G-2100 Continued

The mailing address is:

DHH/MMIS/Retroactive Reimbursement Unit
P.O. Box 91030
Baton Rouge, LA 70821-9030

MMIS Retroactive Reimbursement Unit Responsibilities

If it appears that the *enrollee* may be eligible for reimbursement, the DHH/MMIS/Retroactive Reimbursement Unit staff will request that the *enrollee* provide the following to them:

1. A copy of the bill(s) or other acceptable verification which documents:

   - Medicaid *enrollee*'s name;
   - for doctor and hospital services; the date(s) of service, procedure and diagnosis codes, number of units provided, amount billed, amount paid, and verification of any private insurance payments;
   - for pharmacy services: date filled, National Drug Code, quantity dispensed, number of units provided, amount billed, amount paid, and verification of any private insurance payments;
   - for Durable Medical Equipment: date(s) of service, quantity, number of units provided, diagnosis and procedural codes, documentation of medical necessity from the doctor, amount billed, amount paid, and verification of any private insurance payments;
   - for dental services: date(s) of service, diagnosis and procedure codes per tooth, number of units provided (adults limited to dentures or oral surgery services only), amount billed, amount paid and verification of private insurance payments; and

G-2100 Continued

- proof of any payment made by a third party (such as Medicare, an insurance company, charitable organization, family or friend) towards the bill.

2. Receipt(s) or other acceptable proof showing that the bill was paid by the Medicaid *enrollee* or someone else. If paid by someone else, proof that the eligible is still liable for repayment to the individual who paid the bill.

BHSF Form RRP-V shall be used to request this information. The *enrollee* shall be allowed 15 days to provide the requested documentation, and upon request for additional time, given an extension. If an extension is requested, no more than 15 additional days will be granted. *Enrollees* who fail to provide the requested documentation or fail to request an extension shall have the request for reimbursement denied using BHSF Form 18-RRP.

Upon receipt of information from the *enrollee*, the MMIS Retroactive Reimbursement Unit shall determine if the criteria to qualify for reimbursement has been met. ***Reimbursements are made at the Medicaid rate, less any Third Party payments.***

If all criteria are met, a reimbursement check will be issued to the payee at the Medicaid maximum allowable amount, along with BHSF Form 18-RRP explaining the reimbursement decision.

If all criteria are not met, using BHSF Form 18-RRP, the *enrollee* shall be advised that eligibility for reimbursement has not been established. The *enrollee* shall be given a clear and concise explanation of the reason(s) for ineligibility for reimbursement.

The enrollee will be notified of the final decision using BHSF Form 18-RRP which will contain a detailed explanation of all payment and/or denial information.

The MMIS Recipient Reimbursement Unit will file the agency's copies of all forms and documentation to support reimbursement in the Medicaid *enrollee's* financial eligibility case record.

Recipient Refunds Due to Retroactive Eligibility Policy

If a recipient was Medicaid certified on or after February 15, 1995, the recipient may be eligible for reimbursement of paid medical costs incurred from the first retroactive date of Medicaid eligibility up until the recipient received a medical card. This does not cover those recipients who had a medical card at the time service was delivered.

Providers who have provided Medicaid covered services to such recipients for periods of retroactive coverage may choose to accept the recipient as a Medicaid patient retroactively only after a Medicaid identification card is issued to the recipient.

Providers who agree to bill Medicaid must reimburse the patient immediately the full amount they paid for the Medicaid covered services. Providers do not have the option to refund only the Medicaid allowed amount for the covered Medicaid services; the recipient must be refunded the amount they paid for the services. Providers may not withhold a refund until Medicaid pays on the claim, nor may they apply the amount of the refund to another outstanding balance without the recipient's permission.

Providers who agree to reimburse recipients should follow established claim filing procedures. Claims for dates of service less than one year old may be submitted to Unisys as usual (EDI, pharmacy POS, or paper). Claims for dates of service between one and two years old, and those over two years old, should be filed in accordance with retroactive eligibility procedures on p. 25.

Providers who choose not to accept the recipient as a Medicaid patient retroactively should not reimburse the recipient; the State will reimburse the recipient directly. A provider's ability to participate in the Medicaid program will not be affected if they choose not to accept a Medicaid patient retroactively.

If the provider chooses not to accept the Medicaid recipient retroactively, the recipient should be instructed to contact the MMIS Retroactive Reimbursement Unit at (225) 342-1739 or Toll Free 1-866-640-3905 to obtain reimbursement information.

* Please note that the Provider Contact Letter (RRP-P) is now obsolete.

901 MURRAY STREET
P.O. BOX 551
ALEXANDRIA, LA 71309

MEDICAID PROGRAM
HEALTH SERVICES
FINANCING
SPECIAL NOTICE

WID:
SSN:
WKR:

Dear :

IMPORTANT NOTICE
06/06/1996

TO ALL MEDICAID RECIPIENTS WHO WERE CERTIFIED FOR MEDICAID
ON OR AFTER FEBRUARY 15, 1995

If you were not on Medicaid on February 14, 1995, but were certified for Medicaid benefits after that date. you MAY BE ELIGIBLE FOR REIMBURSEMENT of part or all of medical expenses you have paid, including doctor bills. prescriptions. etc.

To receive reimbursement for any medical bills that you paid, certain conditions have to be met:

1. You must have been found eligible for Medicaid benefits on or after February 15, 1995.
2. The bills must be from the period of time from three months before the month you applied for Medicaid until you received your first Medicaid card.
3. You must have paid the medical bills to Providers who take Medicaid.
4. The medical bills must be for medical services or supplies Medicaid covers.
5. You have not already been reimbursed through Medicaid for your payment of these bills.
6. If you don't already have a copy of the bill marked 'Paid' or a receipt or other provider record showing that the bill was paid, you must obtain this proof of payment from the provider.
7. You must present this proof of payment plus your Medicaid number to your local BUREAU OF HEALTH SERVICES FINANCING(MEDICAID) OFFICE BY DECEMBER 30, 1996.

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

After you submit the paid bills to the local Bureau of Health Services Financing office, we will evaluate your situation. If you meet the above conditions, we will see if the provider will repay you the funds that you paid for medical goods or services. If the provider will not repay you, we will do so (up to the Medicaid rate) as soon as possible.

If you have any questions about this, please contact your local Bureau of Health Services Financing office at:

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MEDICAID PROGRAM
900 MURRAY STREET
P.O. BOX 551
ALEXANDRIA, LA 71309

Phone: 318-484-2420

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E. OADA has developed internal management procedures r billing. A copy of these procedures are housed in the s[illegible]t Secretary's Office of OADA.

F[illegible]ny individual or family unit who is indigent, as [illegible] herewith shall be eligible for reduced co-payment fees [illegible]d on the urine drug screen co-payment sliding fee scale. hen documented medical bills incurred within the 12 onths prior to treatment/service equal or exceed 20 percent the annual gross family unit income, urine drug screens all be provided at reduced cost to the family unit. The eriod of eligibility begins at the date at which liability aches the 20 percent figure through the end of the calendar ear. Such patients with third-party payors shall be provided duced cost medical services or only that portion of their bill r which no third-party payor is or may be liable.

G. Exceptions may be granted at the discretion of the ssistant Secretary or his designee.

Co-payment Sliding Fee Scale for Urine Drug Screen

Income	Dependents				
	1	2	3	4	5+
0 - 2000	$ 2	$ 2	$ 2	$ 2	$ 2
2001 - 3000	4	2	2	2	2
3001 - 4000	8	4	2	2	2
[illegible]1 - 5000	10	8	4	2	2
[illegible] - 6000	12	10	8	4	2
6000+	12	12	10	8	4

AUTHORITY NOTE: Promulgated in accordance with R.S. 8:771 and R.S. 36:258(E).

HISTORICAL NOTE: Promulgated by the Department of Health nd Hospital, Office of Alcohol and Drug Abuse, LR 23:200 February 1997).

Bobby P. Jindal
Secretary

1702#011

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Aid to Families with Dependent Children and Supplemental Security Income—Medicaid Programs

[illegible] Department of Health and Hospitals, Office of the [illegible]ary, Bureau of Health Services Financing adopts the [illegible]ing Rule in the Medical Assistance Program as [illegible]ized by R.S. 46:153 and pursuant to Title XIX of the [illegible]l Security Act, 42 USCA 1396a et seq. This Rule is dopted in accordance with the Administrative Procedure Act, .S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing terminates coverage for the optional eligibility categories, Aid to Families with Dependent Children-Medicaid and Supplemental Security Income - Medicaid, as allowed by Title XIX of the Social Security Act Section 1902(a)(10) and 42 CFR Subpart C Section 435.210.

Bobby P. Jindal
Secretary

9702#051

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Community Care Program—Physician Management Fee

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing increases the physician management fee in the Community Care Waiver Program to $3 per enrolled recipient per month.

Bobby P. Jindal
Secretary

9702#055

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Direct Reimbursement to Recipients
During Period of Retroactive Eligibility

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following Rule in the Medicaid Program as authorized by R.S. 46:153. This Rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following provisions to establish and govern direct reimbursement to a Medicaid

eligible for his payment(s) made to any Medicaid-enrolled provider for medical care, services and supplies delivered during the recipient's period of retroactive eligibility and prior to receipt of the first medical eligibility card (MEC). Reimbursement shall be made only in accordance with all applicable federal and state regulations.

General Provisions

A. Reimbursement shall be made only for payments made to providers of medical care, services and supplies who were enrolled in the Medicaid Program at the time of service.

B. Reimbursement shall be made only for medical care, services and supplies covered by the Medicaid Program at the time of service.

C. Reimbursement shall be made only for medical care, services and supplies delivered during a retroactive eligibility period and prior to receipt of the recipient's first MEC.

D. Reimbursement shall be made only up to the maximum allowable Medicaid rate for the particular service(s) rendered.

E. Reimbursement shall be provided only under the following conditions. Reimbursement shall be made only for eligibles certified for Medicaid coverage beginning February 15, 1995. Reimbursement shall be made for all bills, from any Medicaid-enrolled provider, for medical care, services and supplies covered by the Medicaid Program and rendered during the three months prior to application, as well as bills paid during the period from application to certification.

F. The Medicaid recipient must submit the following documentation to the bureau in order to receive reimbursement. Proof of payment shall be a receipt or similar evidence of payment.

G. Reimbursement for services rendered during any retroactive eligibility period and prior to receipt of the initial MEC for Medicaid eligibles certified beginning February 15, 1995 through the effective date of this Rule shall be made in accordance with the following requirements. Proof in accordance with Subsection F above, along with the recipient's Medicaid identification number must be presented to the local Bureau of Health Services Financing (Medicaid) office by December 30, 1996.

H. Reimbursement of payments for services rendered during any retroactive eligibility period or prior to receipt of the recipient's initial MEC from the effective date of this Rule and henceforth shall be made in accordance with the following requirements:

1. A recipient's intention to make a request for reimbursement must be made known to the local Bureau of Health Services Financing (Medicaid) office within 30 days from the date of the letter sent to the recipient advising him of his right to request reimbursement.

2. Proof in accordance with Subsection F above must be presented to the local Bureau of Health Services Financing (Medicaid) office within 15 days of the request for reimbursement. If the recipient requests an extension on this time limit, it will be provided.

Bobby P. Jindal
Secretary

9702#054

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Hospital Prospective Reimbursement
Methodology for Long-Term Acute Hospitals

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing will prospectively reimburse long-term acute hospitals for psychiatric treatment at the prospective per diem rate established for psychiatric treatment facilities.

Bobby P. Jindal
Secretary

9702#061

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Hospital Prospective Reimbursement
Methodology for Rehabilitation Hospitals

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing amends the Hospital Prospective Reimbursement Methodology Rule by prospectively reimbursing rehabilitation hospitals within the peer groups established for nonteaching hospitals established in the Hospital Prospective Reimbursement Methodology Rule. The appropriate peer group shall be determined according to the number of licensed rehabilitation beds as of March 31 of the year preceding the state fiscal year for which the rates will be in effect. The bureau will continue to apply the criteria contained in the pre-admission and certification and length of stay criteria for Inpatient Hospital Services Rule according to the treatment needs of the individual patient.

Bobby P. Jindal
Secretary

9702#062

PROCEDURES

RECIPIENT REIMBURSEMENT REQUEST RECEIVED

BUSINESS PROCESS STEPS

1. Receive request for reimbursement from enrollee, authorized representative or Parish Medicaid office.
2. Verify enrollee's eligibility information in Recipient Search in LA Medicaid Management Information System (LMMIS), Customer Information Control System (CICS) or Medicaid Eligibility Determination System (MEDS).
3. Perform case search in LA Medicaid Management Information System (LMMIS) to verify that a case doesn't already exist.
4. Retrieve payee information if the enrollee is a minor from Medicaid Eligibility Determination System (MEDS).
5. Assign request to a Medicaid Monitor with a case number for processing in LA Medicaid Management Information System (LMMIS).
6. Document in (ECR) Electronic Case Record the request was received and the monitor the case has been assigned to.
7. Review of information by Medicaid Monitor is done to see if criteria have been met.
   - The provider was enrolled as a LA Medicaid provider on the date the service was received.
   - The enrollee was Medicaid eligible on the date of service.
   - The bills are for services received within the enrollee's eligibility period for reimbursement.
   - Enrollee hasn't received reimbursement from Medicaid, the provider or a third party entity.
   - The bills are for medical care, services, or supplies covered by Medicaid on the date service.
   - Enrollee has provided proof of payment.
8. If criteria is met and no additional information is needed, the claim will be processed.
9. If criteria is not met, the request will be denied and the enrollee will be mailed a Notice of Recipient Reimbursement Decision (BHSF Form 18RRP).
10. If additional information is needed, a Recipient Reimbursement Verification Request Form is mailed to the enrollee and they are given 15 days from the date of the letter to respond.

11. If the enrollee fails to provide the verification within the 15 days the request for reimbursement is denied and a Notice of Recipient Reimbursement Decision (BHSF Form 18 RRP) is mailed to the enrollee. The enrollee is given 30 days to request a fail hearing. If request for an appeal is received, the appeal process will be completed.
12. If the verification needed is submitted, the case is processed.
13. If the received verification is insufficient, the enrollee is given another opportunity to provide the correct information. Policy allows an additional 15 days to provide verification.
    - If the correct information is received, the request is processed.
    - If the information is not provided the request will be denied and a Notice of Recipient Reimbursement Decision (BHSF Form 18RRP) is mailed to the enrollee. The enrollee is given 30 days to appeal the decision. If appeal request is received, the appeal process will be completed.
14. Case information should be scanned into the ECR (Electronic Case Record) within one week of completion. You should verify the scan to make sure it is legible before destroying the case. All original receipts should be returned to the enrollee.

PROCESSING RECIPIENT REIMBURSEMENT REQUEST

BUSINESS PROCESS STEPS

1. Select case from the Data Entry Queue in LMMIS (Louisiana Medicaid Management Information System. Case status will be "added".
2. Select "Add New Request (RRP-R)". Case status will change to "open".
3. Enter Provider number.
4. Select claim type and hit enter.
5. The form that appears will be appropriate for the claim type selected.
6. Enter claim information.
7. Save information. Reimbursement amounts will be calculated automatically.
8. Review for possible errors and invalid claims. Make necessary corrections.
9. Enter price override if necessary. Sometimes a manual calculation is needed for Pharmacy, DME (durable medical equipment) and FQHC (Federally Qualified Health Center and duplicate claims.
10. Enter a reason in the comment section to explain the price override.
11. Select "Pay check" box if not already checked and save all changes. If any edits fail a price will not be calculated and a status of "invalid" will be returned along with the reason for invalidity.
12. Make all necessary comments in "additional notes" and complete the case. If payment is due, case status will change to "Closed – Payment Outstanding". If payment is zero, the status will be "Closed".
13. Mail Recipient Reimbursement Notice of Decision (automatically generated) to the enrollee if the reimbursement amount is zero. Enrollee has 30 days to request an appeal. If appeal request is received, the appeal process is completed.
14. If a payment is outstanding, a payment request will be generated to DHH Fiscal Intermediary for the approved reimbursement amount.
15. Submit case to supervisor for approval 1.) If it is a second check request 2.) If a price override was done or 3.) If the price request exceeds a predetermined system amount. If approved the case remains in "Closed – Payment Outstanding" status. If denied, the case status will be returned to "Open" status for corrections. Once completed the check request is sent to DHH Fiscal Intermediary.
16. Receive check from DHH Fiscal Intermediary (usually on Mondays).
17. Print Notice of Recipient Reimbursement Decision. Notice will automatically appear in the Monitor's print queue in LMMIS System once the check is issued.

18. Mail Notice and check to enrollee. Enrollee is given 30 days to appeal the decision. If an appeal request is received, the appeal process is completed. If check and notice is returned, the Monitor will make necessary changes and mail information to enrollee again. All changes are noted in ECR and in LMMIS.
19. Scan all information related to reimbursement request into the ECR (Electronic Case Record) within one week of completion. Originals should be mailed back to the enrollee.

Recipient Reimbursement

Case Detail Report

Dated 1/8/2009

Case # 12576

Case Parish: IBERIA

Recipient Name: BOUDREAUX , JEANELL

Recipient ID: 7692274165616

Recipient DOB: 1/13/1957

Recipient Address: 728 WEEKS STREET
NEW IBERIA , LA 70560-0000

Recipient Phone #: (337)256-6234

Application Date: 10/31/2007

Reimbursement Periods:
10/1/2007 thru 12/31/2020 - 125

Payee Name: BOUDREAUX, JEANELL **Payee Phone:** (337)256-6234

Payee Address: 728 WEEKS STREET
NEW IBERIA, LA 70560-0000

Provider ID	Provider Name	Claim Type	Paid Amount	Reimbursement Amount
1940984	IBERIA COMP COMM HLTH CTR INC	Professional	$60.00	$60.00

	Group	DOS From	TOS	Paid Amt	Proc	Diag	Units	TPL	TPL	Price	Reimbur	Override	Status	Pay
1		10/19/2007	07	$15.00	T1015		1.000		$0.00	$0.00	$15.00	$15.00	Valid	X
2		10/26/2007	07	$15.00	T1015		1.000		$0.00	$0.00	$15.00	$15.00	Valid	X
3		11/9/2007	07	$15.00	T1015		1.000		$0.00	$0.00	$15.00	$15.00	Valid	X
4		11/26/2007	07	$15.00	T1015		1.000		$0.00	$0.00	$15.00	$15.00	Valid	X
				$60.00					$0.00	Total:	$60.00			

Provider ID	Provider Name	Claim Type	Paid Amount	Reimbursement Amount
1270661	WAL-MART PHARMACY #10-0533	Pharmacy	$109.52	$100.13

	Group	DOS From	Paid Amt	NDC Code	Diag	Units	Emer	Preg	Inpt	Co-Pay	TPL	TPL	Price	Reimbur	Override	Status	Pay
2		10/15/2007	$8.00	00591544301		60.000				$0.50		$0.00	$10.59	$7.50		Valid	X
3		10/19/2007	$26.82	00406036301		40.000				$1.00		$0.00	$24.18	$23.18		Valid	X
4		10/19/2007	$8.00	00591544301		60.000				$0.50		$0.00	$10.59	$7.50		Valid	X
5		10/24/2007	$5.60	53489011902		28.000				$0.50		$0.00	$9.94	$5.10		Valid	X
1		10/27/2007	$4.00	00172208380		30.000				$0.50		$0.00	$7.50	$3.50		Valid	X
6		10/30/2007	$19.46	00406036301		30.000				$1.00		$0.00	$19.58	$18.46		Valid	X
7		11/9/2007	$33.64	00406036301		60.000				$2.00		$0.00	$33.39	$31.39		Valid	X
8		11/9/2007	$4.00	00172208380		30.000				$0.50		$0.00	$7.50	$3.50		Valid	X
			$109.52							TPL:		$0.00	Total:	$100.13			

RRP's Not In System: 0 **System RRP's:** 2 **Case Total RRP's:** 2

LOUISIANA Department of HEALTH and TALS

Recipient Reimbursement

Case Detail Report

Dated 1/8/2009

Payment Tracking

Request Type	Check#	Check Amt	Request Date	Date To Acct	Check Date	Request Status	Administration
Payment	4024454	$160.13	2/15/2008	2/21/2008	2/22/2008	Cleared	Granted
		$160.13					

Letter Tracking

Letter Date	Print Date
2/22/2008	2/26/2008

Notes Tracking

Date	Note	Author
1/25/2008	Received RR request:Iberia Comp. Community Health, UMC, Wal Mart Pharmacy.	maurdb
1/25/2008	Mailed RRP-V to recipient requesting Iberia Comp. Comm. Health CPT codes; UMC itemized bill; due 2/11/08.	maurdb
2/4/2008	Ms. Boudreaux stated she had the info from Iberia C. C. Health Ctr., but not UMC which she can't get until Wednesday. I told her she had until 2/11/08 and if she needed more time to call Ms. Barnes back.	faithful1
2/15/2008	Spoke with Cindy at UMC/Lafayette. She verified that they have billed Medicaid for DOS 10/10/07 through 11/15/07 and will reimburse the recipient directly.	maurdb
2/15/2008	FQHC Provider type 72, Iberia Comp Comm. health Ctr, PPS rate as of 7/1/07 is $161.42. Recipient paid $15.00 for DOS 10/19/07 - 11/26/07.	maurdb
2/[illegible]2008	Case was Completed	maurdb
2/15/2008	Approved Iberia Comp. Comm. Health Ctr; $60.00.	maurdb
2/15/2008	Approved Wal Mart Pharmacy # 0533; $100.13.	maurdb
2/15/2008	Check Request Approved	deborah1

Approval/Denial Notes for Letters

Letter ID	Date	Note	Author
12648	2/15/2008	Your request for reimbursement of your payment(s) for services received on 10/10/07 through 11/15/07 with University Medical Center was not approved because the provider has billed Medicaid and will reimburse you directly.	maurdb
12648	2/15/2008	Your request for reimbursement of your payment(s) for services received on 08/31/2007 with Wal Mart Pharmacy was not approved because you were not eligible for Medicaid on this date of service.	maurdb

Assigned To: maurdb - Barnes, Rosa
Received Date: 1/24/2008
Open Date: 2/15/2008
Add Date: 1/24/2008
Close Date: 2/15/2008
Case Status: Closed - Paid
Date Last Worked: 2/15/2008

Forms/Notices

DATE REC'D	NAME	CASE #	# of Items	Client ID#	Payee SS#	CLIENT INFO DUE	Sent to Data	DATE OF DISP

MMIS
RETROACTIVE REIMBURSEMENT

This case contains
Protected Health Information
Regarding both Enrollees & Providers

All inquiries should be directed to:

Retroactive Reimbursement
(225) 342-1739
or
(866) 640-3905

Recipient Reimbursement Support
Issue Reporting Form

Date: 05/05/05
Name: Kelly McNabb
User ID (in RR): CIBRL63
Security Level (Admin, Prog Spec., etc.): Program Specialist

Web address of problem page (copy and paste): See Attached.

If applicable, send the following analysis info (and anything else pertinent):

Info: *** Monte- I sent this same error message yesterday.

- Case # -
- Provider # -
- Claim ID –
- DOS –
- Paid Amount –
- NDC Code –

Steps to Reproduce:

EXAMPLE: All the info can be "copy and pasted" into this document. If you were Adding a Case, the steps to reproduce are:

- http://unisys3/LMMISInquiry/RecipientReimbursement/AdminQueue.aspx > Click Case Tracking > Click Add New > http://unisys3/LMMISInquiry/RecipientReimbursement/CaseEntry.aspx > Enter "11111111" as Recpient > Select "ACADIA" as Parish > Press Add Case
- ERROR: **Recipient is InEligible. If you feel this is an error, verify data and try again, otherwise Deny Case by clicking button below.**
- (type here)

Description of the Issue: Received the attached error while attempting to "search" for a case while in closed queue.

Expected Behavior:

- **To move thru queue screens.**

Actual Bahavior:

- **See attached error message.**

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P. O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on this notice. I think it is unfair because:

Date: _____

Signature: _____
Applicant/Recipient/Representative

Name: _____
Case ID: _____
Medicaid Analyst: _____
SSN: _____
Date: _____
Office: _____

Phone No. (_____) _____
Address: _____
_____

ELIGIBILITY FOR RETROACTIVE REIMBURSEMENT

The decision of the Federal Court of Appeals in New Orleans requires that we consider reimbursing recipients for any medical bills paid between _____ (the beginning date of eligibility) and _____ (the date the Medicaid Card is expected to be received). Louisiana's **Medicaid Program** will make reimbursements only up to the maximum allowable Medicaid rate.

In order to qualify for reimbursement:

1. The bill(s) must be for medical care, services or supplies received during the dates shown above.

2. The bill(s) must be for medical care, services or supplies covered by the **Medicaid Program** at the time of service.

3. The bill(s) must be for medical care, services or supplies furnished by a provider who was enrolled in the **Medicaid Program** at the time of service.

4. The bill(s) must have been paid during the dates shown above **AND** have not been reimbursed in full by the provider, a third party (such as an insurance company or charitable organization), or already by the **Medicaid Program**.

If your provider refuses to reimburse you the amount you paid and bill LA Medicaid for your retroactive date(s) of service, you may request reimbursement directly from LA Medicaid by sending copies of paid bills which meet the above criteria to the Retroactive Reimbursement Unit at P.O. Box 91030, Baton Rouge, LA 70821-9030 by _____(thirty days from the date of this letter). If you have questions or need additional time to send the bills, write to us or call us at our toll free number 1-866-640-3905 (local Baton Rouge callers must dial 342-1739).

BHSF Form RRP-V
Rev. 06/05
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Recipient Reimbursement Verification Request Form

P.O. Box 91030
Baton Rouge, LA 70821-9030

_____, 20____

Recipient Name _____

Recipient ID #_____

Dear _____:

On _____, you requested reimbursement for bills which you have paid. We have decided that these bills meet the initial criteria for consideration; however, more information is needed to make a decision on the services listed below.

Date(s) of Service	Type of Service	Provider Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

We need you to send us the following information by _____ (15 days from the date of this request).

If you cannot provide the information by this date, you must contact our office at _____ and we can give you extra time to mail it in.

We Need You To Provide The Following:

1) A copy of the bill(s) or a written statement from the provider which shows the following:
   - Name of the recipient receiving the service;
   - If a doctor's office/hospital; the date(s) of service, procedure and diagnosis codes, amount billed, amount you paid, and verification of any private insurance payments (EOB);
   - If a pharmacy; date filled, National Drug Code, quantity dispensed, amount billed, amount you paid, and verification of any private insurance payments (EOB);
   - If Durable Medical Equipment; date(s) of service, quantity, diagnosis and procedure codes, documentation of medical necessity from the doctor, amount billed, amount you paid, and verification of any private insurance payments (EOB);
   - If Dental; date(s) of service, diagnosis and procedure codes per tooth, amount billed, amount paid and verification of private insurance payments (EOB);
   - Proof of any payment made by a third party (such as Medicare, an insurance company, charitable organization, family or friend) towards the bill.

AND

SEE NEXT PAGE FOR IMPORTANT INFORMATION

2) Receipt(s) or other acceptable proof showing that payment was made by you, OR if made by someone else, that you have made or are still responsible for repayment.

If you do not provide this information or contact us for additional time, your request for reimbursement will be denied.

If you have any questions, please feel free to contact our office.

Sincerely,

_____

Program Specialist
DHH/MMIS/Claims Processing Unit

_____

Phone Number

_____

Fax Number

BHSF Form 18-RRP
Rev. 02/05
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Recipient Reimbursement Decision

JEANELL BOUDREAUX
728 WEEKS STREET
NEW IBERIA, LA 70560-0000

Letter Date: 2/26/2008
Recipient: JEANELL BOUDREAUX
Case ID: 12576
Recipient ID: 7692274165616

Dear JEANELL BOUDREAUX:

The following decision(s) has (have) been made on your request for reimbursement of medical bills you paid before you received your Medicaid card. We are only able to repay you for the amount that Medicaid would have paid the provider for these services.

Your request for reimbursement of your payment for services received on 10/15/2007 through 11/26/2007 has been approved. You will receive payment in the amount of $160.13 which is the maximum amount that Medicaid would have paid the provider for these services. Your reimbursement check along with an explanation of payment is attached. Policy reference MEM, G-2100.

Provider: WAL-MART PHARMACY #10-0533
1205 E ADMIRAL DOYLE DR
NEW IBERIA LA 70560-0000
(337)364-3841

From	To	Service Type	Proc/NDC Code	Diag Code	Pay	Paid Amount	TPL Amount	Reimburse Amount	Explanation
10/15/2007	10/15/2007	06	00591544301		Yes	$8.00	$0.00	$7.50	Approved
10/19/2007	10/19/2007	06	00406036301		Yes	$26.82	$0.00	$23.18	Approved
10/19/2007	10/19/2007	06	00591544301		Yes	$8.00	$0.00	$7.50	Approved
10/24/2007	10/24/2007	06	53489011902		Yes	$5.60	$0.00	$5.10	Approved
10/27/2007	10/27/2007	06	00172208380		Yes	$4.00	$0.00	$3.50	Approved
10/30/2007	10/30/2007	06	00406036301		Yes	$19.46	$0.00	$18.46	Approved
11/9/2007	11/9/2007	06	00406036301		Yes	$33.64	$0.00	$31.39	Approved
11/9/2007	11/9/2007	06	00172208380		Yes	$4.00	$0.00	$3.50	Approved

Provider: IBERIA COMP COMM HLTH CTR INC
806 JEFFERSON TERRACE
NEW IBERIA LA 70560-0000
(337)365-4945

From	To	Service Type	Proc/NDC Code	Diag Code	Pay	Paid Amount	TPL Amount	Reimburse Amount	Explanation
10/19/2007	10/19/2007	07	T1015		Yes	$15.00	$0.00	$15.00	Approved

SEE LAST PAGE FOR IMPORTANT INFORMATION

BHSF Form 18-RRP
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IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Recipient Reimbursement Decision

Provider: IBERIA COMP COMM HLTH CTR INC
806 JEFFERSON TERRACE
NEW IBERIA LA 70560-0000
(337)365-4945

From	To	Service Type	Proc/NDC Code	Diag Code	Pay	Paid Amount	TPL Amount	Reimburse Amount	Explanation
10/26/2007	10/26/2007	07	T1015		Yes	$15.00	$0.00	$15.00	Approved
11/9/2007	11/9/2007	07	T1015		Yes	$15.00	$0.00	$15.00	Approved
11/26/2007	11/26/2007	07	T1015		Yes	$15.00	$0.00	$15.00	Approved

Comments

Your request for reimbursement of your payment(s) for services received on 10/10/07 through 11/15/07 with University Medical Center was not approved because the provider has billed Medicaid and will reimburse you directly.

Your request for reimbursement of your payment(s) for services received on 08/31/2007 with Wal Mart Pharmacy was not approved because you were not eligible for Medicaid on this date of service.

Sincerely,

Rosa Barnes
DHH/MMIS/Claims Processing
Phone Number: (225)342-5696

SEE LAST PAGE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with the decision, you may discuss it with a supervisor in the Medicaid Program office. The supervisor can review this decision and give any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you must do so by 3/27/2008 (thirty days from date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the Medicaid program at Reimbursement Unit Office, P.O. Box 91030, Baton Rouge, LA 70821-9030 OR you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself and have anyone else you choose to represent you; present your own evidence or witness; and question any person who testifies against you.

You may be able to get free help by calling the nearest legal assistance office at 1-800-256-1955.

Complete this section ONLY if you want to request a Fair Hearing

I want to appeal the decision of my case as shown on Page 1 of this notice. I think it is unfair because:

Date: _____

Signature: _____
(Applicant/Recipient/Representative)

Phone No.: _____

Address: _____

_____

BHSF Form 18-RRP
Rev. 02/05
Prior Issue Obsolete
IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Notice of Recipient Reimbursement Decision

FLOR LARA
4045 MAYHAWK DRIVE
HARVEY, LA 70058-0000

Letter Date: 12/23/2008
Recipient: JONIZ LARA
Case ID: 15248
Recipient ID: 9941066080598

Dear FLOR LARA:

The following decision(s) has (have) been made on your request for reimbursement of medical bills you paid before you received your Medicaid card. We are only able to repay you for the amount that Medicaid would have paid the provider for these services.

Your request for reimbursement of your payment for services received on 10/15/2008 through 10/15/2008 has been approved. You will receive payment in the amount of $71.57 which is the maximum amount that Medicaid would have paid the provider for these services. Your reimbursement check along with an explanation of payment is attached. Policy reference MEM, G-2100.

Provider: TRUJILLO CARLOS AMD
1111 AVENUE D #813
MARRERO LA 70072-0000
(504)349-6813

From	To	Service Type	Proc/NDC Code	Diag Code	Pay	Paid Amount	TPL Amount	Reimburse Amount	Explanation
10/15/2008	10/15/2008	03	99213		Yes	$80.00	$0.00	$50.36	Approved
10/15/2008	10/15/2008	03	90772		No	$50.00	$0.00	$0.00	Denied Procedure Not Payable
10/15/2008	10/15/2008	03	J2550		Yes	$5.00	$0.00	$2.15	Approved
10/15/2008	10/15/2008	03	36415		Yes	$15.00	$0.00	$2.70	Approved
10/15/2008	10/15/2008	03	85025		Yes	$30.00	$0.00	$9.77	Approved
10/15/2008	10/15/2008	03	J0696		Yes	$20.00	$0.00	$6.59	Approved

Comments

Sincerely,

Tamara Manuel
DHH/MMIS/Claims Processing
Phone Number: (225)342-4665

SEE LAST PAGE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with the decision, you may discuss it with a supervisor in the Medicaid Program office. The supervisor can review this decision and give any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you must do so by 1/22/2009 (thirty days from date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the Medicaid program at Reimbursement Unit Office, P.O. Box 91030, Baton Rouge, LA 70821-9030 OR you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the right to: review your case record and/or any other information which the agency plans to use before the hearing; appear in person; represent yourself and have anyone else you choose to represent you; present your own evidence or witness; and question any person who testifies against you.

You may be able to get free help by calling the nearest legal assistance office at 1-800-256-1955.

Complete this section ONLY if you want to request a Fair Hearing

I want to appeal the decision of my case as shown on Page 1 of this notice. I think it is unfair because:

Date: _____

Signature: _____
(Applicant/Recipient/Representative)

Phone No.: _____

Address: _____

_____

RHC / FQHC

MEDICAID PROSPECTIVE PAYMENT SYSTEM

In accordance with Section 1902(aa)/the provisions of the Benefits Improvement Act (BIPA) of 2000, effective January 1, 2001, payments to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Medicaid services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

The PPS per visit rate is provider specific. To establish the interim baseline rate for 2001, each RHC/FQHC's 1999 and 2000 allowable costs as taken from the RHC/FQHC's filed 1999 and 2000 Medicaid cost reports were totaled and divided by the total number of Medicaid patient visits for 1999 and 2000. The baseline calculation includes all Medicaid coverable services provided by the RHC/FQHC regardless of existing methods of reimbursement for said services. This includes, but is not to be limited to ambulatory, transportation, laboratory (where applicable), KidMed and dental services previously reimbursed on a fee-for-service or other non-encounter basis. **The per visit rate is all-inclusive. RHC/FQHC's are not eligible to bill separately for any Medicaid covered services.** The final PPS rate will be based on audited final cost reports for 1999 and 2000.

For an RHC/FQHC which enrolls and receives approval to operate on or after January 1, 2001, the facility's initial PPS per visit rate will be determined first through comparison to other RHCs/FQHCs in the same town/city/parish. Scope of services will be considered in determining which proximate provider most closely approximates the new provider.

REIMBURSEMENT ADJUSTMENTS

The PPS per visit rate for each facility will be increased annually by percentage increase in the published Medicare Economic Index (MEI) for primary care services. The MEI will be applied on July 1 of each year.

NOTE: Please direct all cost reporting concerns to Carolyn Jones at (225) 342-2495.

REMINDER: RHCs/FQHCs must submit an annual cost report. The cost report must be sent to Trispan at the following address:

Trispan Health Services
5420 Corporate Boulevard, Suite 201
Baton Rouge, LA 70808

Phone: 225/925-8115

RHC/FQHC PROGRAM OVERVIEW

There are 3 components that may be provided under the RHC/FQHC Program: Encounter Visits, KIDMED Screening Services, and EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

RHC/FQHC Encounter Visits

T1015

Encounter visits must be billed using procedure code T1015. **Beginning with January 1, 2005 dates of service (DOS) in addition to the encounter code it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service rendered on subsequent lines. If the encounter detail is not included the claim will deny.**

For obstetrical (OB) services the RHC/FQHC providers must bill the encounter code T1015 with modifier TH and all services performed on that DOS.

RHC/FQHC KIDMED Screening Services

RHC/FQHC KIDMED screening services must be billed on the revised KM3 form using encounter code T1015 along with modifier EP. It will be necessary for providers to indicate the specific screening services provided by entering the individual procedure code for each service rendered on the appropriate line. If a registered nurse performs the screening, providers must enter the appropriate procedure code followed by the modifier TD next to 'Screening Completed by a Nurse'. If immunizations are given at the time of the screening, then those codes continue to be billed on the CMS1500, along with encounter code T1015 and modifier EP. All claims billed using the T1015 and EP modifier **must include** supporting detail procedures.

RHC/FQHC EPSDT Dental, Adult Denture Services and Expanded Dental Services for Pregnant Women (EDSPW)

Dental services must be billed on the 2002 or 2002,2004 ADA claim form using the encounter code D0999. It will be necessary for providers to indicate the specific dental services provided by entering the individual procedure code for each service rendered on subsequent lines. All claims billed using D0999 **must include** supporting detail procedures.

NOTE: The dental encounter, D0999, may be billed on the same date of service as the encounter codes T1015(RHC/FQHC), T1015 TH(OB encounter), and/or T1015 EP(KIDMED screening).

Provider Type: 72

FQHCs

	Parish	Provider Number	Provider Name	FYE	Used	Final/ As Filed	New Base Rate	MEI Increase 7/1/2002	PPS RATE	MEI Increase 7/1/2003	PPS RATE	MEI Increase 7/1/2004	PPS RATE	MEI Increase 7/1/2005	PPS RATE	MEI Increase 7/1/2006	PPS RATE	MEI Increase 7/1/2007	PPS RA
1	57	44082	Abbeville Community Health Center **Effective 8/17/2000**	5/31	00/01	Finalized Cos	103.28	0.026	105.97	0.03	109.14	0.029	112.31	0.031	115.79	0.028	119.03	0.021	
2	32	6117	Albany Medical Clinic **Effective 5/19/2008**	6/30	PROX	State Wide Av	124.26											0.021	
3	36	94119	Algiers Fischer Community Health **Effective 5/1/1992**	12/31	99/00	Finalized Cos	122.61	0.026	125.80	0.03	129.58	0.029	133.34	0.031	137.47	0.028	141.32	0.021	
4	17	44743	Baton Rouge Primary Care Collaborative **Effective 6/24/2004**	6/30	PROX	Capitol City F	111.46				111.46	0.029	114.69	0.031	118.25	0.028	121.56	0.021	
5	17	94805	Capitol City Family Health Center **Effective 11/17/1997**	1/31	99/00	Finalized Cos	105.46	0.026	108.21	0.03	111.46	0.029	114.69	0.031	118.24	0.028	121.56	0.021	
6	13	94080	Catahoula Parish Hospital District #2 **Effective 4/1/1990**	12/31	99/00	Finalized Cos	105.84	0.026	108.59	0.03	111.85	0.029	115.09	0.031	118.66	0.028	121.98	0.021	
7	19	45029	Clinton Middle Health Center **Effective 5/1/05**	8/31	PROX	State Wide Av	114.42						114.42	0.031	117.97	0.028	121.70	0.021	
8	15	44837	Concordia Community Health Center **Effective 12/1/2005**	12/31	PROX	State Wide Average	118.39							0.031	118.39	0.028	121.70	0.021	
9	36	17413	Daughters of Charity Health Center **Effective 7/1/2008**	6/30	PROX	State Wide Average	126.5												
10	36	45084	Daughters of Charity Health Center **Effective 7/1/2008**	6/30	PROX	State Wide Average	126.5												
11	36	17390	Daughters of Charity Health Center **Effective 7/1/2008**	6/30	PROX	State Wide Average	126.5												
12	8	70601	David Raines Community Helath Center/Bossier **Effective 5/29/2008**	6/30	PROX	State Wide Average	124.26											0.021	
13	9	94163	David Raines Community Health Center/Shreveport **Eff 9/30/92**	6/30	99/00	Finalized Cos	119.11	0.026	122.20	0.03	125.87	0.029	129.52	0.031	133.53	0.028	137.27	0.021	
14	9	94654	David Raines Community Health/Gilliam **Eff 3/5/96**	6/30	99/00	Finalized Cos	116.94	0.026	119.98	0.03	123.58	0.029	127.16	0.031	131.11	0.028	134.78	0.021	
15	9	12871	David Raines Community Health Center/Dental Mobile Unit **Eff 6/19/2008**	6/30	PROX	State Wide Av	124.26											0.021	
16	24	45768	East Iberville Elem/High SBHC **Effective 2/1/2007**	2/28	PROX	State Wide Average										0.028	121.7	0.021	
17	26	94765	East Jefferson Community Health Center **Effective 3/21/97**	6/30	99/00	Amended Finalized	83.67	0.026	85.85	0.03	88.43	0.029	90.99	0.031	93.82	0.028	96.44	0.021	
18	17	44158	Excelth Family Health Center-**Effective 1/1/2001**	12/31	PROX	Hlth Corp	78.76	0.026	80.81	0.03	83.23	0.029	85.64	0.031	88.30	0.028	90.77	0.021	
19	40	01396	Fairway Terrace Site-**Effective 8/8/2007**	2/28	PROX	State Wide Average	124.26										121.70	0.021	
20	23	94098	Iberia Comprehensive Community Health Center Inc. **Eff 1/1/92**	5/31	99/00	Finalized Cost Reports	137.18	0.026	140.75	0.03	144.97	0.029	149.17	0.031	153.80	0.028	158.10	0.021	
21	24	45770	Iberville Elementary School Based Health **Effective 2/1/07**	2/28	PROX	State Wide Av	121.70											0.021	
22	39	44196	Innis Community Health Center - **Effective 9/18/2001**	10/31	PROX	State Wide Av	105.46	0.026	108.21	0.03	111.46	0.029	114.69	0.031	118.24	0.028	121.55	0.021	
23	19	44838	Jackson Complex Health Center-**Effective 12/1/2005**	8/31	PROX	State Wide Av	118.39							0.031	118.39	0.028	121.70	0.021	
24	26	45279	Jefferson Community Health Center **Effective 9/14/05**	12/31	PROX	Capitol City F	117.97								117.97	0.028	121.70	0.021	
25	88	45148	Jefferson Comprehensive Health-Katrina Enrollment **Eff 8/27/05-7/31/08**	12/31											79.27		79.27		
26	39	45061	Livonia Community Health Center - **Effective 9/18/05**	3/31	PROX	State Wide Av	117.97								117.97	0.028	121.70	0.021	
27	40	01393	Miracle Plaze Service Site- **Effective 8/8/2007**	2/28	PROX	State Wide Av	124.26										121.70	0.021	
28	34	01979	Morehouse Community Medical Clinic-**Effective 10/12/2007**	7/31	PROX	State Wide Av	124.26										121.70	0.021	
29	53	44810	Multipractice Clinic **Effective 2/21/06**	2/21	99/00	State Wide Av	118.39							0.031	118.39	0.028	121.70	0.021	
30	36	94081	N.O.H.D.-H.C.H.P. **Effective 4/1/1990**	10/31	99/00	Finalized Cos	98.67	0.026	101.24	0.03	104.28	0.029	107.30	0.031	110.63	0.028	113.73	0.021	
31	36	94102	Outpatient Medical Center- **Effective 4/1/1990**	1/31	99/00	Finalized Cos	80.39	0.026	82.48	0.03	84.95	0.029	87.42	0.031	90.13	0.028	92.65	0.021	
32	58	94104	Outpatient Medical Center- **Effective 4/1/1990**	1/31	99/00	Finalized Cos	109.00	0.026	111.83	0.03	115.19	0.029	118.53	0.031	122.20	0.028	125.63	0.021	
33	35	94101	Outpatient Medical Center- **Effective 4/1/1990**	1/31	99/00	Finalized Cos	88.87	0.026	91.18	0.03	93.92	0.029	96.64	0.031	99.64	0.028	102.43	0.021	
34	39	03418	Pointe Coupee Central High School Based Clinic-**Effective 3/11/2008**	10/31	PROX	State Wide Average	124.26											0.021	
35	37	44143	Primary Health Services Center **Eff 3/6/2001**	12/31	PROX	Primary Healt	97.01	0.026	99.53	0.03	102.52	0.029	105.49	0.031	108.76	0.028	111.81	0.021	
36	37	94908	Primary Health Services Center - **Effective 3/5/1999**	12/31	99/00	Finalized Cos	97.01	0.026	99.53	0.03	102.52	0.029	105.49	0.031	108.76	0.028	111.81	0.021	
37	40	44375	Rapides Primary Health Care Center - **Effective 5/22/2002**	2/28	PROX	Natchitoches	88.87	0.026	91.18	0.03	93.92	0.029	96.64	0.031	99.64	0.028	102.43	0.021	
38	19	45027	RKM Primary Care - **Effective 5/1/2005**	8/31	PROX	State Wide Av	114.42						114.42	0.031	117.97	0.028	121.70	0.021	
39	45	44464	St. Charles Community Health Clinic - **Effective 4/1/2003**	7/31	PROX	St. Bernard C	129.22			0.03	133.10	0.029	136.96	0.031	141.21	0.028	145.16	0.021	
40	26	45290	St. Charles Community Health Clinic - **Effective 5/13/05**	2/28	PROX	State Wide Av	114.83						114.83	0.031	118.39	0.028	121.70	0.021	
41	24	94411	St. Gabriel Health Clinic-Effective **Effective 1/3/1995**	6/30	99/00	Finalized Cos	125.15	0.026	128.41	0.03	132.26	0.029	136.10	0.031	140.32	0.028	144.25	0.021	
42	46	94320	St. Helena Community Health Center-**Effective 9/30/1993**	6/30	99/00	Finalized Cos	119.49	0.026	122.60	0.03	126.27	0.029	129.94	0.031	133.96	0.028	137.72	0.021	
43	50	02808	St. Martin Community Health Center- **Effective 1/16/2008**	12/31	PROX	State Wide Av	124.26										121.70	0.021	
44	49	94185	SW LA Primary Health Care Clinic-**Effective 2/1/1993**	6/30	99/00	Finalized Cos	122.86	0.026	126.06	0.03	129.84	0.029	133.61	0.031	137.75	0.028	141.61	0.021	
45	10	94082	SWLA Center for Health Services **Effective 4/1/1990**	1/31	99/00	Finalized Cos	148.75	0.026	152.62	0.03	157.20	0.029	161.75	0.031	166.77	0.028	171.44	0.021	
46	55	45282	Teche Action Clinic-Houma **Effective 5/11/2005**	5/31	PROX	State Wide Av	114.48							0.031	118.03	0.028	121.70	0.021	
47	51	94092	Teche Action Clinic **Effective 4/1/1990**	5/31	99/00	Finalized Cos	104.18	0.026	106.89	0.03	110.10	0.029	117.52	N/A	117.52	0.028	120.51	0.021	
48	54	44866	Tensas Community Health Center Inc- **Effective 4/3/2006**	12/31	PROX	State Wide Av	118.39							0.031	118.39	0.028	121.70	0.021	
49	89	44983	Watch-Katrina Enrollment **Effective 8/27/2005-7/31/2008**	12/31											85.09/87.64		85.09/87.64		8
50	61	1038814	West Baton Rouge Primary Care **Effective 4/16/2008**	6/1	PROX	State Wide Av	124.26											0.021	
51	21	94603	Wisner Medical Clinic **Effective 9/19/2005**	12/31	99/00	Finalized Cos	85.37	0.026	87.59	0.03	90.21	0.029	92.83	0.031	95.70	0.028	98.38	0.021	
			Total FQHC=51 Through 9/8/2008			Last Updat	7/23/08												

Watch and Jefferson Comprehensive are out of state providers in Arkansas and
ippi who were allowed to enroll in Louisiana Medicaid following Hurrican
Their reimbursement methodlogy was determined using the statewide
in their states.

Provider Type 79

PROVIDER BASED RURAL HEALTH CLINICS

	Parish	Provider Number	Provider Name	PPI	Hospital	FYE	FY's Used	Final/ As Filed	New Base Rate	MEI Increas 7/1/2002	PPS RATE	MEI Increas 7/1/2003	PPS RATE	MEI Increas 7/1/2004	PPS RATE	MEI Increas 7/1/2005	PPS RATE	MEI Increase 7/01/2006	PPS RATE
1	57	44808	Abbeville General Hospital Clinic Eff 1/1/06		Abbeville General Hospital	12/31	PROX	Jeanerette	99.66									0.028	102
2	2	45484	Allen Parish Hospital Rural Health Center Eff 2/20/07		Allen Parish Hospital Service District No. 3	6/30	PROX	Elton Rura	106.22										106
3	53	94395	Amite Rural Health Clinic - Eff 9/16/94	1	Hood Memorial Hospital	9/30	99/00	Finalized C	56.98	0.026	58.46	0.03	60.21	0.029	61.96	0.031	63.88	0.028	65
4	5	94376	Bunkie General Hospital RHC Eff 9/1/94	4	Bunkie General Hospital	6/30	99/00	Finalized C	77.74	0.026	79.76	0.03	82.15	0.029	84.54	0.031	87.16	0.028	89
5	5	45263	Bunkie Gen Hosp-Family Care Clinic Eff 9/21/05		Bunkie General Hospital	6/30	PROX	Bunkie Ger	87.16								87.16	0.028	89
6	7	44391	Christus Coushatta RHC - Eff 8/02/02	4	Christus Health W Central LA	6/30	PROX	Tri-Ward C	69.42	0.026	71.23	0.03	73.36	0.029	75.49	0.031	77.83	0.028	80
7	41	44465	Christus Coushatta Ringgold RHC - Eff 1/1/03	4	Christus Health W Central LA	6/30	00/01	Finalized Cost Report	85.10		85.10	0.03	87.65	0.029	90.19	0.031	92.99	0.028	95
8	11	44393	Citizens Rural Health - Eff 10/30/02	4	Citizens Hospital	3/31	PROX	Winters	106.48		106.48	0.03	109.68	0.029	112.86	0.031	116.36	0.028	119
9	62	94505	Community Medical Clinic Eff 7/17/95	1	West Carroll Memorial Hospital	6/30	99/00	-96.66	97.07	0.026	99.59	0.03	102.58	0.029	105.56	0.031	108.83	0.028	111
10	42	94600	Delhi Rural Health Clinic -Eff 10/18/1995	4	Richland Parish Hospital	9/30	99/00	Finalized C	96.07	0.026	98.57	0.03	101.53	0.029	104.47	0.031	107.71	0.028	110
11	16	44593	Desoto Regional Family Medicine - Eff 4/1/03		Desoto Regional Health System	12/31	PROX	Christus Ri	85.10		85.10	0.03	87.65	0.029	90.19	0.031	92.99	0.028	95
12	18	44653	East Carroll Medical Center - Eff 4/26/04		West Carroll Memorial Hospital	12/31	PROX	Lake Provic	141.43				141.43	0.029	145.53	0.031	150.04	0.028	154
13	2	45636	Elizabeth Family Health Clinic Eff 1/8/07		Rapides Healthcare System, LLC	12/31	PROX	Elton Rural	106.22										106
14	27	94792	Elton Rural Health Clinic-Eff 1/1/1998	1	Savoy Medical Center	12/31	99/00	As Filed	92.16	0.026	94.56	0.03	97.39	0.029	100.22	0.031	103.32	0.028	106
15	46	45960	Family Health of St. Helena LL- Eff 3/29/2007			12/31													65
16	18	44806	Family Medical Clinic - Eff 11/7/05		East Carroll Parish Hospital	5/31	PROX	The Family	108.90								108.90	0.028	111
17	21	44995	Franklin Medical Center RHC- Eff 6/20/05		Franklin Medical Center	4/30	PROX	Northeast I	74.59							0.031	76.90	0.028	79
18	54	44099	Franklin Medical Center RHC - Eff 2/1/00	1	Franklin Medical Center	4/30	00/01	Finalized C	121.69	0.026	124.85	0.03	128.60	0.029	132.33	0.031	136.43	0.028	140
19	54	44798	Franklin Medical Center RHC - Eff 9/15/05		Franklin Medical Center	4/30	PROX	Franklin M	136.43								136.43	0.028	140
20	59	44045	Franklinton Rural Health Clinic - Eff 3/1/00	4	Riverside Medical Center	12/31	00/01	Cost	106.02	0.026	108.78	0.03	112.04	0.029	115.29	0.031	118.86	0.028	122
26	23	94463	Jeanerette Rural Health Clinic Eff 5/8/95	1	Iberia General Hospital	9/30	99/00	Finalized C	88.90	0.026	91.21	0.03	93.94	0.029	96.66	0.031	99.66	0.028	102
27	25	44823	Jonesboro Family Care Clinic Eff 10/25/05		Tri-Ward General Hospital	9/30	PROX	Tri-Ward Clinic								0.031	77.83	0.028	80
28	36	44286	Lady of the Sea Medical Clinic-Cutoff-Eff 4/15/02		Lady of the Sea General Hospital	6/30	PROX	OLOL Assu	78.52	0.026	80.56	0.03	82.98	0.029	85.38	0.031	88.03	0.028	90
29	29	45925	Lady of the Sea Med Clinic-Gold Mead - Eff 1/18/05		Lady of the Sea General Hospital		PROX	Jeanerette	96.66							0.031	99.66	0.028	102
30	29	45767	Lady of the Sea Medical Clinic-Larose -Eff 2/21/05		Lady of the Sea General Hospital		PROX	Jeanerette	96.66							0.031	99.66	0.028	102
31	18	94452	Lake Providence Medical Clinic RHC Eff 2/3/1995	1	West Carroll Memorial Hospital	6/30	99/00	Finalized C	133.83	0.026	137.31	0.03	141.43	0.029	145.53	0.031	150.04	0.028	154
32	13	44971	LaSalle Primary Healthcare Center - Eff 11/29/04		LaSalle Hospital	9/30	PROX	Winters	132.33							0.031	136.43	0.028	140
33	57	1012050	Maurice Community Care Clinic- Eff-7/24/07		Abbeville General Hospital														
34	42	94508	Northeast LA Health Center-Eff 5/22/1995	1	Richardson Medical Center	9/30	99/00	Finalized C	68.60	0.026	70.38	0.03	72.49	0.029	74.59	0.031	76.90	0.028	79
35	62	94358	Oak Grove Medical Clinic RHC- Eff 7/25/1994	1	West Carroll Memorial Hospital	6/30	99/00	Finalized C	115.99	0.026	119.00	0.03	122.57	0.029	126.12	0.031	130.03	0.028	133
36	2	45855	Oberlin Family Health Clinic Eff 1/5/07		Rapides Healthcare System, LLC	12/31	PROX	Elton Rural	106-22										106
37	4	94832	OLOL Assumption Rural Health Eff 5/27/98	1	OLOL Assumption Rural Health	6/30	99/00	As Filed	78.52	0.026	80.56	0.03	82.98	0.029	85.38	0.031	88.03	0.028	90
38	60	44135	Plain Dealing Medical Clinic - CHOW 6/1/01	1	Springhill Medical Services	12/31	99/00	Finalized C	118.06	0.026	121.13	0.03	124.77	0.029	128.39	0.031	132.37	0.028	136
39	43	1021971	Sabine Medical Center RHC-Effective 11/16/07																
40	43	1037605	Sabine Medical Center RHC # 2-Effective 4/9/2008																
41	49	94791	Savoy Family Care-Eff 1/1/98	1	Savoy Medical Center	12/31	99/00	As Filed	124.66	0.026	127.92	0.03	131.76	0.029	135.58	0.031	139.78	0.028	143
42	60	44829	SMC/Doctors Clinic - Effective 4/4/06	12/31	PROX	Butler-Abshire			132.37							0.031	132.37	0.028	136
43	12	94433	South Cameron Memorial Hospital Eff 1/30/95	1	South Cameron Memorial Hospital	10/31	99/00	Finalized	45.37	0.026	46.55	0.03	47.95	0.029	49.34	0.031	50.87	0.028	52
44	46	45433	St. Helena Parish Hospital- RHC EFF 7/28/06		St Helena Parish Hosptial	10/31	PROX	Health Clinic	65.67										69
45	37	1460	Sterlington Clinic EFF 8/3/07																
46	18	94787	The Family Practice Clinic Eff 9/24/97	1	East Carroll Parish Hospital	5/31	99/00	Finalized C	97.13	0.026	99.66	0.03	102.65	0.029	105.62	0.031	108.90	0.028	112
47	56	94604	Tri-Ward Clinic- Eff 10/17/95	4	Tri-Ward General Hospital	12/31	99/00	Finalized C	69.42	0.026	71.23	0.03	73.36	0.029	75.49	0.031	77.83	0.028	80
48	56	44208	Union General RHC - Eff 7/10/01	1	Union General Hospital	6/30	PROX	Clinic	69.42	0.026	71.23	0.03	73.36	0.029	75.49	0.031	77.83	0.028	80
49	56	44954	Union Clinic of Marion - Eff 3/09/05		Union General Hospital	6/30	PROX	Clinic	75.49							0.031	77.83	0.028	80
50	10	45278	Vinton Medical Clinic Eff 1/2/06		West Calcasieu Cameron Hospital	12/31	PROX	Health	73.01								73.01	0.028	75
51	62	94394	West Carroll Medical Clinic Eff 10/25/2004	1	West Carroll Memorial Hospital	6/30	99/00	Finalized C	128.47	0.026	131.81	0.03	135.76	0.029	139.70	0.031	144.03	0.028	148
52	24	52946	Westside Rural Health Services- Effective 5/24/06	6/30	PROX	Prime Med	99.60							0.031	99.60	0.028	102.39	0.021	104
53	21	40874	Wisner Rural Health Clinic- Eff 4/5/2007		Caldwell Memorial Hospital	12/31	PROX		119.62										119
54	11	94399	Winters Clinic- Eff 10/4/1994	1	Caldwell Memorial Hospital	12/31	99/00	Finalized C	103.79	0.026	106.48	0.03	109.68	0.029	112.86	0.031	116.36	0.028	119
55	43	44724	Zwolle Rural Clinic - Eff 3/25/04		Desoto Regional Health System	9/30	PROX	Christus Ri	87.65					0.029	90.19	0.031	92.99	0.028	95

Provider Type: 87

INDEPENDENT PROVIDERS

	Parish	Provider Number	Name	FYE	FY's Used	Final/ As Filed	New Base Rate	MEI Inc 7/1/2002	PPS RATE	MEI Inc 7/1/2003	PPS RATE	MEI Inc 7/1/2004	PPS RATE	MEI Inc 7/1/2005	PPS RATE	MEI Inc 7/1/2006	PPS RATE	MEI Inc 7/1/2007	PPS Rate	MEI Inc 7/1/2008	PI Ra
1	1	1037745	Acadia Family Clinic Eff 4/11/2008	12/31	PROX		91.64											0.021	91.64	0.018	
2	51	94890	Acadiana Family Practice Eff 8/3/98	12/31	99/00	Finalized CR	77.62	0.026	79.64	0.03	82.03	0.029	84.41	0.031	87.02	0.028	89.46	0.021	91.34	0.018	
3	07	44295	Blenville Family Clinic - Eff 5/29/02	12/31	PROX	Tri-Ward Clinic	69.42	0.026	71.23	0.03	73.36	0.029	75.49	0.031	77.83	0.028	80.01	0.021	81.69	0.018	
4	14	94432	Butler-Abshire Rural Health Clinic Eff 2/6/1995	12/31	99/00	Finalized CR	83.53	0.026	85.70	0.03	88.27	0.029	90.83	0.031	93.65	0.028	96.27	0.021	98.29	0.018	
5	39	44753	Brian LeBlanc, M.D. Eff 10/7/04	6/30	PROX	Court-ordered	64.43						77.41	0.031	79.81	0.028	82.05	0.021	83.77	0.018	
6	39	44751	Carl McLemore, M.D. - Eff 10/7/04	6/30	PROX	Court-ordered	64.43						77.41	0.031	79.81	0.028	82.05	0.021	83.77	0.018	
7	22	44852	Cenla Rural Health Centers LLC, - Eff 4/11/06	12/31	PROX	Marksville FC	78.33							0.031	78.33	0.028	80.52	0.021	82.21	0.018	
8	10	45612	Chadha Medical Rural Health Clinic Eff 2/1/07	12/31	PROX	Marksville FC	80.52									0.028	80.52	0.021	82.21	0.018	
9	53	1020303	Children First Kidmed Effective 10/19/2007	12/31	PROX		79.85											0.021	79.85	0.018	
10	31	44854	Family First Medicine-Eff 2/1/06	12/31	PROX	Park City -Mind	78.21							0.031	73.75	0.028	78.21	0.021	79.85	0.018	
11	48	52730	Family First Medicine Center of Reserve-Eff 3/28/2006	12/31	PROX										84.31	0.028	86.67	0.021	88.49	0.018	
12	03	94814	Family Medical Clinic - Donaldsonville-Eff 2/20/98	12/31	99/00	Finalized CR	75.20	0.026	77.16	0.03	79.47	0.029	81.77	0.031	84.31	0.028	86.67	0.021	88.49	0.018	
13	04	94829	Family Medical Clinic - Pierre Part-Eff-4/27/98	12/31	99/00	Finalized CR	68.18	0.026	69.95	0.03	72.05	0.029	74.14	0.031	76.44	0.028	78.58	0.021	80.23	0.018	
14	57	44802	Gardiner Center Health Clinic - Eff 1/05/06	3/31	PROX	Acadiana Fam	87.02								87.02	0.028	89.46	0.021	91.34	0.018	
15	40	12579	Healthy Steps Pediatrics	12/31	PROX		82.21											0.021	82.21	0.018	
16	23	94839	James Russell Romero MD RHC Eff 9/4/98	12/31	99/00	Finalized CR	59.18	0.026	60.72	0.03	62.54	0.029	64.35	0.031	66.35	0.028	68.21	0.021	69.64	0.018	
17	05	13104	KD Wellness Center, LLC Eff 7/2/2008	12/31	PROX		83.69													0.018	
18	27	44248	Lake Arthur Health Clinic - Eff 4/1/02	9/30	PROX	James Romero	59.18	0.026	60.72	0.03	62.54	0.029	64.35	0.031	66.35	0.028	68.21	0.021	69.64	0.018	
19	39	44752	Louis V. Montelaro, M.D. - Eff 10/7/04	6/30	PROX	Court-ordered	64.43						77.41	0.031	79.81	0.028	82.05	0.021	83.77	0.018	
20	05	94713	Marksville Family Care Center (Kalifey Medical Clinic)	6/30	99/00	Finalized CR	69.86	0.026	71.68	0.03	73.83	0.029	75.97	0.031	78.33	0.028	80.52	0.021	82.21	0.018	
21	09	94299	Medical & Surgical Clinic Eff 7/21/93	9/30	99/00	Finalized CR	88.76	0.026	91.07	0.03	93.80	0.029	96.52	0.031	99.51	0.028	102.30	0.021	104.45	0.018	
22	60	10829	Minden Ladies Rural Health Clinic-Eff 7/19/07	12/31	PROX		79.85											0.021	79.85	0.018	
23	33	94849	L.P. Neumann Jr. MD APMC Eff 7/2/98	8/31	99/00	Finalized CR	65.48	0.026	67.18	0.03	69.20	0.029	71.20	0.031	73.41	0.028	75.47	0.021	77.05	0.018	
24	33	44651	Thomas A. Neumann, M.D. LTD - Eff 4/29/04		PROX	L.P. Neumann					69.20	0.029	71.20	0.031	73.41	0.028	75.47	0.021	77.05	0.018	
25	05	44857	Newell Gauthier, Jr RHC Eff 5/25/06	12/31	PROX	Marksville FC	80.52							0.031	78.33	0.028	80.52	0.021	82.21	0.018	
26	05	44864	Newell Gauthier, Jr RHC Eff 6/30/06	12/31	PROX	Marksville FC	80.52							0.031	78.33	0.028	80.52	0.021	82.21	0.018	
27	23	1027537	New Iberia Maternal-Child Clinic. Effective 1/9/2008	12/31	PROX		83.77											0.021	83.77	0.018	
28	53	94456	North Oaks OB/GYN RHC Eff 12/28/94	12/31	99/00	Finalized CR After Field Audit	67.85	0.026	69.62	0.03	71.71	0.029	73.79	0.031	76.08	0.028	78.21	0.021	79.85	0.018	
29	39	44750	Paul Rachal, M.D. - Eff 10/7/04	6/30	PROX	Court-ordered	64.43						77.41	0.031	79.81	0.028	82.05	0.021	83.77	0.018	
30	60	94464	Park City Health Center RHC/ Minden Family Care Eff 2/10/95	3/31	99/00	Finalized CR	67.86	0.026	69.62	0.03	71.71	0.029	73.79	0.031	76.08	0.028	78.21	0.021	79.85	0.018	
31	15	1021849	Pediatric and Adolescent Clinic Eff 11/7/07	12/31	PROX		82.21											0.021	82.21	0.018	
32		1448605	The Poplarville Clinic-Katrina Emergency Enrollment.		39447										72.59	0.028	74.62	0.021	76.19	0.018	
33	24	44005	Prime Medical (Iberville Community HC) - Eff 2/21/00	12/31	00/01	Finalized CR	88.83	0.026	91.14	0.03	93.88	0.029	96.60	0.031	99.60	0.028	102.39	0.021	104.54	0.018	
34	23	1037591	Raymond F Schneider Memorial Clinic, LLC Eff 4/9/2008	12/31	PROX	James Romero	69.64											0.021	69.64	0.018	
35	04	44511	Reddy Family Med Clinic-Napoleon -Eff 5/16/03	12/31	PROX	Reddy - D'ville	79.47		79.47		79.47	0.029	81.77	0.031	84.31	0.028	86.67	0.021	88.49	0.018	
36	24	94980	Reddy Family Med Clinic-Plaq -Eff 11/4/99	12/31	00/01	Finalized CR	71.19	0.026	73.04	0.03	75.23	0.029	77.41	0.031	79.81	0.028	82.05	0.021	83.77	0.018	
37	24	94924	Reddy Family Medical Clinic - White Castle Eff 5/28/95	12/31	99/00	Finalized CR	119.63	0.026	122.74	0.03	126.43	0.029	130.10	0.031	134.13	0.028	137.89	0.021	140.78	0.018	
38	13	44749	Riverpark Medical Clinic - Jonesville - Eff 11/4/04	12/31	PROX	Marksville FC	75.97						75.97	0.031	78.33	0.028	80.52	0.021	82.21	0.018	
39	32	40823	Riverside Family Medicine-Eff 3/27/2007	12/31	PROX		78.21										78.21	0.021	79.85	0.018	
40	64	00852	Shalom Clinic for Children -Eff 7/2/07	12/31	PROX	Marksville FC	82.21											0.021	82.21	0.018	
41	27	44532	Shirley Medical Clinic - Eff 7/2/03		PROX	James Romero	62.54				62.54	0.029	64.35	0.031	66.35	0.028	68.21	0.021	69.64	0.018	
42	47	44880	St. James Primary Care Eff 6/22/03	12/31	PROX	Reddy - D'ville	84.31							0.031	84.31	0.028	86.67	0.021	88.49	0.018	
43	48	45762	St. James Primary Care Eff 2/1/2007	12/31	PROX		78.21										78.21	0.021	79.85	0.018	
44	47	44979	St. Joseph Medical Clinic - Eff 7/11/05	12/31	PROX	Reddy - D'ville	84.31								84.31	0.028	86.67	0.021	88.49	0.018	
45	50	1027545	St. Martinville-Child Clinic- Eff 1/9/2008	12/31	PROX		83.77											0.021	83.77	0.018	
46	57	1016179	Women's Clinic-Effecitve 9/5/2007	12/31	PROX		91.64											0.021	91.64	0.018	
47	40	1020184	Woodworth Family Medicine-Effective 10/19/2007	12/31	PROX		82.21											0.021	82.21	0.018	
48	14	44214	WK Claiborne Regional Health -Eff 12/01/01	12/31	PROX	Butler-Abshire	85.70		85.70	0.03	88.27	0.029	90.83	0.031	93.65	0.028	96.27	0.021	98.29	0.018	
49	08	44428	WK Plain Dealing Clinic - Eff 11/07/02	12/31	PROX	Med & Surg	91.07		91.07	0.03	93.80	0.029	96.52	0.031	99.51	0.028	102.30	0.021	104.45	0.018	

Total Independent Based RHC=49

Last Updat 2/18/08

DME

From: Kelly Mcnabb
To: Recipient Reimbursement Unit
Date: 10/11/2006 2:32 PM
Subject: DME Referrals

10/11/06

After speaking with Stephanie this date, she stated the following information is needed for her to even begin to process a DME request:

1) Procedure Codes
2) Diagnosis Codes
3) Prescription for each item type

If these three items have not been submitted by the enrollee, please request these items.

If not provided, deny case without sending to Stephanie. If provided, send to Stephanie for pricing.

Thanks! K Mc

Kelly McNabb, Medicaid Program Supervisor
DHH/BHSF/MMIS/Claims Processing Unit
225-342-9322

Sample

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

November 18, 2008

TO: Ms. Stephanie Guarino
Unisys

FROM: Tamara T. Manuel, MMIS
Recipient Reimbursement

RE: Joyce L. Vickers
ID #: 8581038692696
Received in MMIS: 11/14/08, 11/18/08

Attached please find medical expenses which the above referenced recipient has requested reimbursement. We need your assistance in pricing these items.

If you have any questions, please contact my office at (225) 342-4665.

Thanking you in advance for your assistance.

TM:tm

Attachments

PHARMACY

From: Rachel Broussard
To: Kelly Mcnabb
Date: 1/11/05 9:20AM
Subject: Re: Co-Pay Exemptions

Kelly,

The following pharmacy services are exempt from the copayment requirement:

Services furnished to individuals under 21 years of age.

Services furnished to pregnant women if such services are related to the pregnancy, or to any other medical condition which complicate the pregnancy.

Services furnished to any individual who is an inpatient in a hospital, long term care facility, or other medical institution. SEE ATTACHED LTC TYPE CODE 11-1

Emergency services provided in a hospital, clinic, physician office or other facility equipped to furnish emergency care.

Family planning services and supplies.

The copay schedule is:

Calculated State Payment	Copayment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.00 or more	$3.00

< 10.01 = .50 copay
< 25.01 = $1.00 "
< 50.01 = $2.00 "
> 50.01 = $3.00 "

Rec'd from Janet Rose

```
DRGI 200062020604                    DRUG FILE          LAST-ACT: 12092002   T
NDC:  00062-0206-04 TOS: 06 ADD-DATE: 12311978 END-DATE: 00000000 TAPE-IND: 0
      GENERIC DESCRIPTION              DOSAGE    STRENGTH   UNIT   ROUTE
GRISEOFULVIN,MICROSIZE                 ORAL SUSP 125MG/5ML  2      1 ORAL
TRADENAME: GRIFULVIN V          Qty --> SIZE: 00000120 . 000 TOP-200-IND: 000

THER CL:  W3A LMAC-IND: 0000 PAC-RVW:   0    PAC   ERR   E-DATE      R  SOURCE R
DRUG-CLASS: F REPK-IND:    0 PAC-DOC:   0    750   000   09151989    _       _
DEA-CODE:   0 AGE-MIN:    00 MSG-IND:   0    720   233   11071988
DESI-CODE:  0 AGE-MAX:    99 OBS-IND:   0    000   000   00000000
CMS-IND:    N SEX:         0 BIOEQ:    ZC    000   000   00000000
UNIT-DOSE:  0 FAMPLAN:     0 FLAG2:    Y00
MAINT-IND:  0 PA-IND :     1 DTC:     024 ORAL ANTIFUNGALS
     ACQ-COST    E-DATE  R      LMAC-COST   E-DATE  R      FUL -COST   E-DATE  R
C: 0000 . 32733 12042002 _    0000 . 00000 00000000 _    0000 . 00000 00000000 _
2: 0000 . 30447 03082002      0000 . 00000 00000000      0000 . 00000 00000000
3: 0000 . 27189 06142001      0000 . 00000 00000000      0000 . 00000 00000000
4: 0000 . 25925 09092000      0000 . 00000 00000000      0000 . 00000 00000000
5: 0000 . 24500 09161999      0000 . 00000 00000000      0000 . 00000 00000000

COMMENT:                                  MANUF: ORTHO DERM      HICL: 004126
STR-NUM:  00000125 . 000 STR-UN: MG       VOL-NUM: 0005 . 000 VOL-UN: ML
    GCN:  42390     GCN SEQ NUM:  009517  LAST PAY DATE:  06172003
TRANSACTION COMPLETED, ENTER NEXT
```

1 = tablet
2 = ml*
3 = gm*
*ml - milliter
*gm - gram

LOOK AT PAC

750 = Acq - Cost

) = LMAC OR FUL
* use the lesser of the 2 unit price
* If zero use the 1 with the #

) 755 - goes to M.J.'s group for pricing

PAC 750

Take Acq - Unit Price x Qty of units Billed x .865 (Independent - 13.5%) Pharmacy
" " x .85 (Chain - 15%)

+ dispo fee - copay

) PAC 7K0

Take unit price x Qty of units Billed + dispo fee - copay
* use LMAC or FUL - lesser of 2*

6) PAC 755

Take unit price x Qty of units Billed - copay (no Dispo Fee)
↓
Acq-cost

```
DRGI 200002751101                    DRUG FILE          LAST-ACT: 09092003   C
NDC:  00002-7511-01 TOS: 06 ADD-DATE: 12192000 END-DATE: 00000000 TAPE-IND: 1
        GENERIC DESCRIPTION              DOSAGE    STRENGTH   UNIT   ROUTE
INSULIN NPL/INSULIN LISPRO               VIAL      75-25 U/ML   2   G SUBCUTANE
TRADENAME: HUMALOG MIX 75/25                SIZE: 00000010 . 000 TOP-200-IND: 000

THER CL:  C4G LMAC-IND: 0000 PAC-RVW:  0  PAC  ERR   E-DATE     R   SOURCE R
DRUG-CLASS: F REPK-IND:    0 PAC-DOC:  0  755  000   12112000   _          _
DEA-CODE:   0 AGE-MIN:    00 MSG-IND:  1   000  000   00000000
DESI-CODE:  0 AGE-MAX:    99 OBS-IND:  0   000  000   00000000
CMS-IND:    S SEX:         0 BIOEQ:   ZB   000  000   00000000
UNIT-DOSE:  0 FAMPLAN:     0 FLAG2:  Y00
MAINT-IND:  1 PA-IND :     2 DTC:    019 INSULINS✓

    ✓ACQ-COST    E-DATE  R     LMAC-COST    E-DATE  R     FUL -COST   E-DATE  R
C: 0010 . 04250 09042003  _   0006 . 69500 09042003  _   0000 . 00000 00000000 _
2: 0009 . 21450 12192002      0006 . 14300 12192002      0000 . 00000 00000000
3: 0008 . 11500 07182002      0005 . 41000 07182002      0000 . 00000 00000000
4: 0007 . 51350 01162002      0005 . 00900 01162002      0000 . 00000 00000000
5: 0007 . 15500 12112000      0004 . 77000 12112000      0000 . 00000 00000000

COMMENT: AWP+50%                          MANUF: ELI LILLY & CO. HICL: 019949
STR-NUM:  00000000 . 000 STR-UN:          VOL-NUM: 0000 . 000 VOL-UN:
    GCN:  22681     GCN SEQ NUM:  047172  LAST PAY DATE:  09302003
TRANSACTION COMPLETED, ENTER NEXT
```

755 is the category used for diabetic drugs

Ex: Insulins

Always use the "Acq-cost" for unit price

Per Mel in Pharmacy. 9/30/03

Formula

(Acq-cost X units) – copay

VOIDING CHECKS

Retroactive Reimbursement procedures to do a Stop Payment of a check or to Void a check.

STOP PAYMENT OF A ***RR CHECK***

(Lost, Stolen or Never Received)

1. If a recipient states they never received the RR check or the check was lost, an AFFIDAVIT form must be sent to the recipient to complete and sign along with witnesses' signatures.
2. After the Program Monitor receives the AFFIDAVIT, a letter is sent to Financial Management to the attention of Lagatha Felton requesting stop payment of the check. See example attached. Note: The Blanchard Funding Source is as follows: a) Pharmacy claim amounts – 1813; b) Professional claim amounts – 0713.
3. Ask Lagatha Felton to notify you by email that the Stop Payment process is completed.
4. Once notified by Ms. Felton, go into the RR case and click Void Check.
5. In order to send another RR check, Click on the heading of CHECK: SEND CHECK. (Note: If corrections have to be made to address or payee name, complete and save these changes before Clicking on *"CHECK: SEND CHECK"*.)

Sample

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

DATE: June 9, 2008

TO: Lagatha Felton
Payment Management

FROM: Tamara T. Manuel
MMIS/Claims Processing

RE: Stop Payment

Please stop payment of the following:

Payee:	Kimberly Jones
Recpt:	Dustin Jones
Med. #:	3703061158101
Check #:	4024497
Check Date:	02/29/2008
Amount:	$324.69
Funding:	0713 - 0
	1813 - $324.69

This check was never received by recipient.

Please credit the above amount to the indicated funding source.

If further information is needed, please contact me at 342-4665.

Thanks!

TM:tm

AFFIDAVIT REGARDING CHECK NEVER RECEIVED OR CHECK LOST

STATE OF LOUISIANA

MEDICAL ASSISTANCE PROGRAM
RECIPIENT REIMBURSEMENT PROGRAM

DESCRIPTION OF CHECK

AMOUNT OF CHECK $

DATE OF CHECK CHECK NUMBER

BANK ON WHICH CHECK IS DRAWN ACCOUNT NUMBER
Bank One

NAME OF PAYEE OR CURATOR FOR PAYEE RECIPIENT NAME RECIPIENT ID NUMBER

The undersigned authority _____ says:

That she/he is the person named as the payee or the curator for the payee of the above described check (Check appropriate block):

- ☐ That said check is lost;
- ☐ That she/he has never received, endorsed, delivered or negotiated said check;
- ☐ That she/he requests an order of a stop payment be issued.

That said check will be returned by her/him to the Bureau of Health Services Financing if found.

WITNESSES:

1. Name_____

Address_____

_____

2. Name_____

Address_____

_____

3. Name_____

Address_____

_____

_____
SIGNATURE OF PAYEE OR CURATOR FOR PAY

DATE _____

Return to:
DHH - BUREAU OF HEALTH SERVICES FINANCING
MMIS/CLAIMS PROCESSING
P. O. BOX 91030
BATON ROUGE, LA 70821

Recipient Reimbursement

Case Detail Report

Dated 1/9/2009

Case # 12763

Case Parish: OUACHITA

Recipient Name: JONES , DUSTIN

Recipient ID: 3703061158101

Recipient DOB: 7/20/1990

Recipient Address: 5802 CYPRESS STREET LOT 11
WEST MONROE , LA 71291-0000

Recipient Phone #: (318)282-6187

Application Date: 1/17/2008

Reimbursement Periods:

12/1/2007	thru	12/31/2020	- 014
7/1/2001	thru	6/30/2007	- 014
6/1/1998	thru	7/31/1998	- 001
5/1/1998	thru	5/31/1998	- 071
4/1/1998	thru	7/31/1998	- 001
11/1/1997	thru	3/31/1998	- 071
3/1/1997	thru	10/31/1997	- 001
2/1/1997	thru	2/28/1997	- 071
4/1/1993	thru	5/31/1995	- 014

Payee Name: JONES, KIMBERLY **Payee Phone:** (318)325-0432

Payee Address: 5802 Cypress Street - Lot 11
WEST MONROE, LA 71291-0000

Provider ID	Provider Name	Claim Type	Paid Amount	Reimbursement Amount
1232254	WALGREEN PHARMACY #10510	Pharmacy	$375.97	$324.69

	Group	DOS From	Paid Amt	NDC Code	Diag	Units	Emer	Preg	Inpt	Co-Pay	TPL	TPL	Price	Reimbur	Override	Status	Pay
1		12/29/2007	$112.99	00597001314		14.700				$0.00		$0.00	$94.48	$94.48		Valid	X
2		12/29/2007	$39.99	00093714618		6.000				$0.00		$0.00	$45.46	$39.99		Valid	X
3		12/29/2007	$222.99	00173069600		60.000				$0.00		$0.00	$190.22	$190.22		Valid	X
			$375.97							TPL:		$0.00	Total:	$324.69			

RRP's Not In System: 0 **System RRP's:** 1 **Case Total RRP's:** 1

Payment Tracking

Request Type	Check#	Check Amt	Request Date	Date To Acct	Check Date	Request Status	Administration
Payment	4024497	$324.69	2/22/2008	2/28/2008	2/29/2008	Void	Not Needed
Void	4024497	$0.00	7/9/2008			Void	Not Needed
Payment	4029839	$324.69	7/14/2008	7/17/2008	7/18/2008	Sent	Not Needed
		$649.38					

Letter Tracking

Letter Date	Print Date
2/29/2008	3/3/2008
7/18/2008	10/8/2008

Notes Tracking

Date	Note	Author
2/22/2008	Case reassigned. T. Manuel on FMLA effective 2/14/08..	deborah1
2/22/2008	Payee submitted 3 Rx receipts from Walgreen Pharmacy dated 12/29/07.	deborah1
/2008	Case was Completed for Walgreen Pharmacy (12/29/07).	deborah1

LOUISIANA
Department of
LTH and
PITALS

Recipient Reimbursement

Case Detail Report

Dated 1/9/2009

3/31/2008	Payee she hasn't rec'd check. Current address is 5802 Cyprus T. Lot 11. Check mailed to 801 Splane Dr. Apt. C. States forwarding order on file. Suggested she check w/P.O. because it hasn't been returned.	deborah1
3/31/2008	Notice and check was returned (forwarding order expired). Info. was remailed to forwarding address (Cyprus St) on 3/11/08. Notes were made in ECR 3/11/08.	deborah1
3/31/2008	Called above number to inform Kimberly Jones that the check had been remailed. Only number on file (# above) is for Subway. I was informed she no longer is employed there.	deborah1
4/15/2008	Ms. Jones called and states that she did not get the RR check. I told her that it was returned by the post office and was remailed to the 5802 Cyprus Lot 11 address.	maurdb
4/24/2008	Ms. Jones called again and states that she has not received Dustin's check. I informed her that an affadavit will be sent to her to sign, witness and return.	maurdb
4/24/2008	Gave case print out to Ms. Davis to review.	maurdb
6/9/2008	Affidavit received on 5/30/08. Ms. Davis gave me to process this today. Sent memo to Financial rep. Lagatha Felton for a stop payment on check #4024497.	faithful1
7/9/2008	I contact Lagatha Felton in Financial Mgt. and she stated she has received the confirmation of the STOP Payment for Check #4024497. I will request another check.	faithful1
[illegible]2008	Case was Edited - Change address.	faithful1
[illegible]/2008	Case was Completed	faithful1

Approval/Denial Notes for Letters

Letter ID	Date	Note	Author

Assigned To: faithful1 - Manuel, Tamara
Received Date: 2/13/2008
Open Date: 2/22/2008
Add Date: 2/13/2008
Close Date: 7/14/2008
Case Status: Closed - Payment Outstanding
Date Last Worked: 7/14/2008

VOID PAYMENT OF A ***RR CHECK***

(Error Made on Check)

1. If the recipient sends back the RR check or Program Monitor notes a mistake on check, send a letter along with the original check to Lagatha Felton to void the check. See example attached.

2. Once Ms. Felton has notified you by email that the check has been voided, go into the RR System to the make the appropriate corrections and click save.

3. To reissue the check, Click on the heading of CHECK: SEND CHECK. (Note: If corrections have to be made to address or payee name, complete and save these changes before Clicking on *"CHECK: SEND CHECK"*.)

Sample

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

DATE: December 30, 2008

TO: Lagatha Felton
Payment Management

FROM: Tamara T. Manuel
MMIS/Claims Processing

RE: Void Check

Please void the attached check and credit it to the indicated funding source in the Blanchard Reimbursement account.

Payee:	Madison Menard
Recpt:	Madison Menard
Med. #:	5955971166413
Check #:	4034548
Check Date:	12/29/2008
Amount:	$1,150.00
Funding:	0713 - $1,150.00
	0813 - $0

I will re-issue this check with the payee's name corrected on the check.

If further information is needed, please contact me at 342-4665.

Thanks!

TM/tm

Attachment

Recipient Reimbursement

Case Detail Report

Dated 1/9/2009

Case # 15324

Case Parish: CALCASIEU

Recipient Name: MENARD , MADISON M

Recipient ID: 5955971166413

Recipient DOB: 1/29/2004

Recipient Address: 2406 SALMON ST
LAKE CHARLES , LA 70605-0000

Recipient Phone #: (337)477-0004

Application Date: 6/13/2008

Payee Name: MENARD, NICOLE

Payee Address: 2406 SALMON ST
LAKE CHARLES, LA 70605-0000

Reimbursement Periods:

5/1/2008	thru	12/31/2020	- 014
1/1/2004	thru	1/31/2005	- 002

Payee Phone: (337)477-0004

Provider ID	Provider Name	Claim Type	Paid Amount	Reimbursement Amount
1553085	NILESHWAR RAMGOPAL S	Professional	$4,700.00	$1,150.00

	Group	DOS From	TOS	Paid Amt	Proc	Diag	Units	TPL	TPL	Price	Reimbur	Override	Status	Pay
1		7/17/2008	09	$4,700.00	V5261		2.000		$0.00	$1,150.00	$1,150.00		Valid	X
				$4,700.00					$0.00	Total:	$1,150.00			

RRP's Not In System: 0 **System RRP's:** 1 **Case Total RRP's:** 1

Payment Tracking

Request Type	Check#	Check Amt	Request Date	Date To Acct	Check Date	Request Status	Administration
Payment	4034548	$1,150.00	12/22/2008	12/25/2008	12/29/2008	Void	Not Needed
Void	4034548	$0.00	12/30/2008			Void	Not Needed
Payment		$1,150.00	12/30/2008	1/8/2009		Pending	Granted
		$2,300.00					

Letter Tracking

Letter Date	Print Date
12/29/2008	

Notes Tracking

Date	Note	Author
12/22/2008	Case was Completed	faithful1
12/30/2008	Check Number 4034548 Voided	faithful1
12/30/2008	Case was Edited	faithful1
12/30/2008	Send letter to Financial Mgt. to void check #4034548 and I edited Payee's name to mother Nicole Menard.	faithful1
12/30/2008	New Check Requested	faithful1
1/5/2009	Check Request Approved	deborah1

Approval/Denial Notes for Letters

Letter ID	Date	Note	Author

Assigned To: faithful1 - Manuel, Tamara

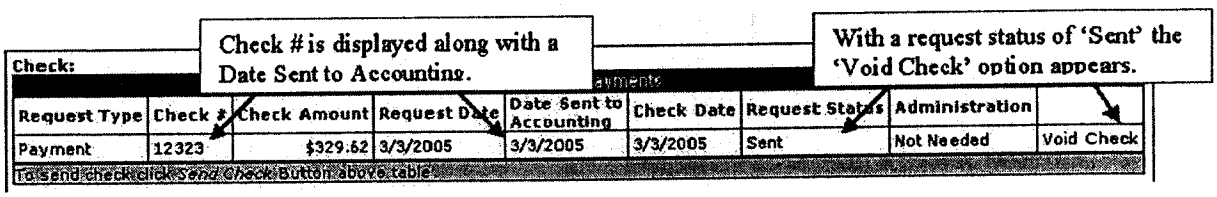
Received Date: 12/22/2008

Open Date: 12/22/2008

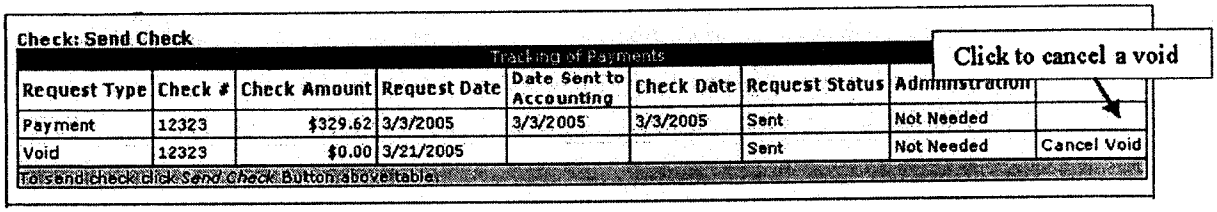
Date: 12/22/2008

Close Date: 12/22/2008

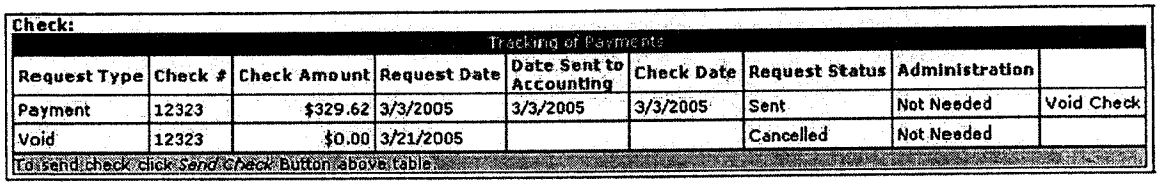
Case Status: Closed - Payment Outstanding



After a sent check has been voided, the Request Type is 'Void' and the Check Amount, Date Sent to Accounting, and Check Date fields are all cleared.

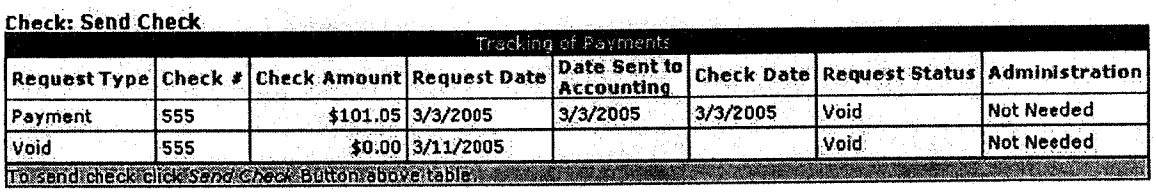


In the event that the void was a mistake, click **Cancel Void** and the Void request will be cancelled.



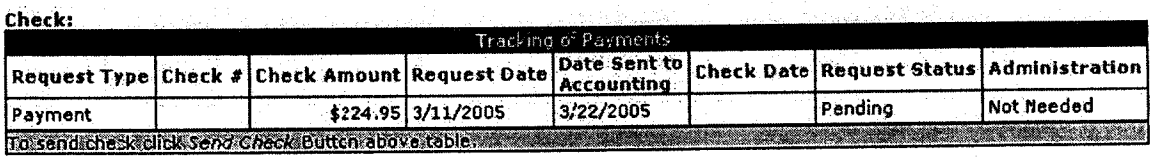
5.13.5 Request Status – Void

If a check has been voided, another check can be requested for the case by clicking the **Send Check** button. When a check void has been confirmed through bank reconciliation, both the check and void request have status set to 'Void'.



5.13.6 Request Status – Pending

If a check is pending, it cannot be cancelled or voided, and the **Send Check** option is not available.



5.13.7 Request Status – Clear

When bank reconciliation shows that a check has been cleared, the check status is set to clear. Shown below is the screen when the checks have been cleared through bank reconciliation. A new check cannot be requested, and the check cannot be voided or cancelled if a check has been cleared.

Check:

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration
Payment	123456	$224.95	3/11/2005	3/2/2005	3/22/2005	Cleared	Not Needed

to send check click Send Check button above table

CLEARANCES

From: Kelly Mcnabb
To: Recipient Reimbursement Unit
Date: 9/26/2005 3:56:21 PM
Subject: Anesthesia reimbursement

09/26/05

The information forwarded is a list of information that must be provided by the eligible in order for Anesthesia to be priced accurately.

When you receive a request for Anesth. reimbursement, please obtain the information shown below and bring to me. We are going to try to work with Program Operations in pricing these claims.

Thanks! K Mc

>>> Renee Haines 9/26/2005 3:20:24 PM >>>
Kelly,
I wanted to send you a basic list of things needed for correct anesthesia reimbursement. Then, you and Darla can decide later how we can best move forward-
1) Is the provider of service the anesthesiologist, a CRNA, or did the physician provide conscious sedation?
2) Are the digits in the "unit" box units or minutes? Medicare requests actual units (after conversion) while Medicaid requests minutes (and then the conversion of 15 minutes = 1 unit is done)
3) What surgical procedure code was billed and what anesthesia code is being billed?
4) Sometimes, we need to verify that the surgery and/or anesthesia was/were not related to pain management as Medicaid doesn't pay for pain management, at this time.
Hope this helps and let me know which direction we're going in-
Renee

CC: Audrey PIPER; Jenny M. non Unisys Smith

REIMBURSEMENT REQUEST - PREGANCY

SELF-PAY CATEGORY:

Global fee is used by Provider for an individual with or without Health insurance AND doesn't know that the individual was/is determined to be eligible for Medicaid..

LaChip sends Form RRR-R and the provider ***does not send back or states he/she will not accept person as a Medicaid patient.*** Follow the steps below:

1. Call Provider to get Medicaid Procedure Codes for each date-of-service.

2. Get the amount the Provider charges for each Procedure Code.

3. If no insurance is involved, go ahead and reimburse recipient.

   Note: The recipient will not be reimbursed by Medicaid for additional services received after the receipt of the Medicaid Card (if she chooses to stay with this Provider).

4. If health insurance is involved, then call the insurance company and get the amount/percentage they will pay for each procedure. *Example: Gallaghner Ins. Administrators will pay 80% on each claim if Provider is verified as an in-network doctor for First Health.*

5. Also, see if client has a deductible. If she has met the deductible, complete insurance calculations.

6. If not, asked how much she needs to pay before she meets the deductible. Client's insurance will not pay anything on claims until deductible is met. Client would be reimbursed the full Medicaid amount or her paid amount whichever is less.

MEDICAID CATEGORY:

When an individual is pregnant and the provider knows and accepts Medicaid, they automatically bill Medicaid listing all procedure codes and amounts charged for each date-of-service. If insurance is involved, EOB must be attached.

Providers do have an option whether to reimburse Medicaid recipients for retro timeframe.

From: Kelly Mcnabb
To: Recipient Reimbursement Unit
Date: 3/3/2006 9:11:18 AM
Subject: Circumcision Pricing

03/03/06

FYI-

Due to our not using/entering diagnosis codes in the RR system, our system is "validating" routine circumcision procedure codes 54150, 54152, 54160, and 54161, regardless of their diagnosis codes.

Effective immediately, we must verify the diagnosis code for all circumcisions and override any system "payments" for procedure codes with a diagnosis code of V50.2. Diagnosis code V50.2 is NOT to be paid.

Once Program Operations has completed the testing of their LIFT regarding this issue, we will request a "RR System Update" to require the diagnosis code be entered in the RR system for the pricing of circumcision procedure codes only. However, until then, we are forced to "manually" adjust the pricing of these codes. Remember to document your verificaiton of the diagnosis code in the override notes.

I am attaching an e-mail previously researched by Janice Ihaza regarding the above.

Thank you all for your attention to this matter.

CC: Audrey PIPER; Jenny Smith

From: Janice IHAZA
To: Angeler LUCAS; Audrey PIPER; Beatrice Williams; Bernice GARY; Connie Coleman; Dawn Collins; Deborah Davis; Janice Buckley; Kelly Mcnabb; Sonya Silvio
Date: 6/10/2005 9:16:52 AM
Subject: CLAIMS AND REIMBURSEMENT

NEW CIRCUMCISION POLICY

>>> Judy CAIN 06/10/05 9:05 AM >>>
Per your question this morning, the diagnosis code for routine circumcision is V50.2. When the Department defunded routine circumcision effective April 21, 2005, this was accomplished by having UNISYS program to deny CPT codes 54150, 54152, 54160, and 54161 whenever the diagnosis code was V50.2 - *routine circumcision* for Type of Service codes 03, 07, 08, and 15. Hope this information is useful.

Judy D. Cain, Program Manager
Program Operations
Telephone: (225) 342-9490
FAX: (225) 342-1411
jcain@dhh.la.gov

From: Terri NORWOOD
To: JANET ROSE; Janice IHAZA; Kelly Mcnabb; Tamara Manuel
Date: 2/3/04 10:35AM
Subject: Re: DENI

The Expanded Dental Services for Pregnant Women (EDSPW) Program was implemented on November 1, 2003. An emergency rule was published regarding this program and the services it covers.

I drafted provider policy and guidelines which was mailed to all provider types that are allowed to bill dental claims. Unisys or I would be able to share this information with you if you need it.

Thanks,

Terri Norwood, Program Specialist
DHH/Medicaid/Program Operations
225-342-9403

>>> Kelly Mcnabb 2/3/2004 9:50:15 AM >>>
02-03-04

Tamara brought to my attention an issue regarding Dental Claims.

We are already using TOS 04 and 21 to determine if a procedure is payable; however, in addition to those two TOS's, Tamara has discovered TOS 18 which coveres a female between the ages of 21 thru 59. Therefore, we should be running this TOS for female dental procedures within this age frame. This TOS is covered effective 11-01-03. **(Tamara's case was a 40 year old pregnant woman)**

Pam, if you have any information regarding this additional TOS, please let us know. I remember at the Provider training we attended last year, Unisys was stating that **all** medical assistance needed by a **pregnant woman** would be covered because the mothers health directly impacted the health of the unborn child. This may be falling under that issue, however, I've not seen anything in writing.

Kelly McNabb, Program Specialist
DHH/BHSF/MMIS/Claims Processing Unit
225-342-9322

From: Terri NORWOOD
To: Janice I'HAZA
Date: 5/6/03 1:55PM
Subject: Re: MMIS -DENTAL

Yes, please see the underlined sentence in my reply email. Come by if you need more details.

Thanks, Terri

>>> Janice I'HAZA 05/06/03 01:15PM >>>
THANK YOU TERRI,

ONE MORE QUESTION, HAS ANY OF THE DENTAL PROCEDURE CODES CHANGES?

>>> Terri NORWOOD 05/06/03 01:01PM >>>
Effective May 1, 2003, dental was divided into 2 different types of service - TOS 04 (Adults 21 years of age & older) and TOS 21 (EPSDT Under 21). Also, every dental procedure code now begins with a "D" **and there were dental procedure codes that were either deleted or added effective May 1, 2003.**

In order to obtain information from DENI related to a dental procedure code you must now first determine the age of the recipient to determine whether it will be under TOS 04 or TOS 21.

For EPSDT (TOS 21) DENI entry you would type: DENI(space)(ZERO)(5 digit procedure code which now begins with a "D")(TOS). For example to obtain information related to procedure code D0210 for EPSDT, you would enter DENI 0D021021. For Adult (TOS 04) you would change the last 2 digits in the above example to a "04" (DENI 0D021004).

Janice has an example of a DENI screen print if you have difficulties or you may contact me if you have further questions.

Thanks, Terri

>>> Janice I'HAZA 05/05/03 09:13AM >>>
TERRI PLEASE ADVISE MY CO-WORKERS ON THE NEW DENTAL PROCEDURE FOR MMIS.

THANKS,

Prenatal 18

From: Peggy Matherne
To: Tamara Manuel
Date: 10/17/2008 12:47 PM
Subject: UNCLAIMED PROPERTY

Below are contacts to check on unclaimed property:

Toll-Free in Louisiana at 1-888-925-4127
or 225-219-9400 in Baton Rouge or Out-of-State

U.S. Mail

John Kennedy, State Treasurer
Attn: Unclaimed Property Division
626 Main Street Baton Rouge, Louisiana 70801
or
P. O. Box 91010 Baton Rouge, La. 70821

From: Kelly Mcnabb
To: Dexter Campbell; JANET ROSE; Janice IHAZA; Pamela Brown; Tamara Manuel
Date: 12/22/03 11:05AM
Subject: Pediasure Formula

Pediasure Formula is reimbursable through Blanchard IF it is prescribed by a doctor with a procedure code. (NOT an NDC #)

Dexter, I spoke to Stephanie at Unisys and she stated that three things are absolutedly necessary in order for her to make a decision; 1) The type formula itself; 2) How many calories per day the child needs; and 3) The percent of daily calories provided by the prescribed formula. There may be some additions to this, however, this is the information Stephanie gave me today when I called her. So, go ahead and submit the requests you have, with this information.

*** Unit: These are to be forwarded to Stephanie Guarino as we would a DME request.

Kelly McNabb, Program Specialist
DHH/BHSF/MMIS/Claims Processing Unit
225-342-9322

In/Out Patient Hospital Claims - Unisys Corp.
P.O. Box 91021
Baton Rouge, LA 70821

From: Darla Ratcliff
To: Kelly Mcnabb
Date: 5/11/2006 3:36:17 PM
Subject: Re: TOS 07 Enhanced Fundings

Kelly,

Regarding enhanced reimbursments, there are currently 3 'groups' that I am aware of:

Professional services when rendered to a recipient age 0 (newborn) through age 15 years (TOS 07). Nurse Practitioner/Clinical Nurse Specialists and Physician Assistants are reimbursed at 80% of this rate. These rates are based on recipient age only if this code is on TOS 07, the min/max age will be in the range of 0-15.

CommunityCARE enhanced rates are for enrolled Primary Care Physicians when they render a service to a CommunityCARE enrolled recipient (also TOS 07). This is not related to age and is restricted to PCPs. It is also a very limited number of codes. (I will forward a list of these to you).

Rehabilitation services rendered to recipients age 0 to age 3 years. These enhanced rates are on TOS 20 and apply to the following provider types: Home Health Agency, Outpatient Rehab, Freestanding Rehab facility, and Health Services Providers.

There are many variations in claims pricing details. The above are just a few that relate to your specific question!

>>> Kelly Mcnabb 5/11/2006 2:56:24 PM >>>
05/11/06

It was brought to my attention by J. Buckley/T. Manuel this PM that TOS 07 has enhanced funding for certain procedures provided to enrollees who fall into certain categories (ex: age, etc). We discovered this when an enrollee complained about the amount of her retro reimbursement check regarding RR case #2943; procedure code 67904; priced at TOS 03.

How can we identify procedure codes that fall into TOS 07 (enhancements) in the event that we need this information for future retro reimbursement pricing?

Thank you for your assistance.

Kelly McNabb, Medicaid Program Supervisor
DHH/BHSF/MMIS/Claims Processing Unit
225-342-9322

APPEALS

APPEAL PROCESS FOR RECIPIENT REIMBURSEMENTS

BUSINESS PROCESS STEPS

1. Receive appeal request in the mail from Bureau of Appeals, recipient or authorized representative.
2. Log appeal request in Tracking Log (Excel document). Tracking is done by supervisor.
3. Assign task to complete Summary of Evidence to Monitor.
4. Monitor review case. If review indicates an administrative error, an agency reversal is done (originally denied case reopened and processed). The enrollee and the Bureau of Appeals are notified of the agency reversal. The enrollee is mailed a new Notice of Recipient Reimbursement Decision along with a check if request was approved. The enrollee has 30 days to appeal this decision. If another appeal request is received, the appeal process is completed. If the enrollee is given an explanation of the denial and withdraws their appeal request, the Bureau of Appeals is notified of their request by mail. The Bureau of Appeals will issue a letter to both the agency and the enrollee confirming the withdrawal request. All information regarding the appeal will be documented and scanned into the ECR (Electronic Case Record).
5. Prepare Summary of Evidence and attach supporting documents if an agency error was not made.
6. Review of Summary of Evidence and supporting documents completed by supervisor.
7. Mail Summary of Evidence to Bureau of Appeals.
8. Supervisor receives letter from Bureau of Appeals scheduled hearing. Hearing date is entered in Tracking Log
9. Monitor notified of hearing date.
10. Appeal hearing held with Appeal Law Judge, agency representative, enrollee and authorized representative (if enrollee chooses to have one).
12. Receive decision from Bureau of Appeals. If agency decision is upheld, Monitor documents and scans all information into ECR (Electronic Case Record). The enrollee has the right to seek judicial review by a higher court. If the decision is in favor of the enrollee, a directive is issued by the Bureau of Appeals giving specific instructions concerning action to be taken. Action must be reported within 14 days to the Bureau of Appeals. The enrollee is given 30 days to appeal this decision also. If the enrollee submits an appeal, the appeal process is completed.

Request wasn't filed timely

SUMMARY OF EVIDENCE

IDENTIFYING INFORMATION:

Name: Amy Carlimi
Address: 131 Lazy Creek Drive
Mandeville, LA 70471
Telephone #: (504)421-0247

I.D. #: 3767195397666
SSN: 438-63-0219
Docket #: None Assigned

ACTION APPEALED:

Ms. Amy Carlimi is appealing the denial of her request for retroactive reimbursement through the Department of Health and Hospitals, Medicaid Reimbursement Section.

EXPLANATION OF ACTION AND APPLICABLE POLICY:

On September 28, 2007, the Retroactive Reimbursement Unit received from Ms. Amy Carlimi, a request for reimbursement. Ms. Carlimi submitted receipts dated 8/3/07 and 8/9/07 from Center for Women's Health, unpaid bills from Quest Diagnostics for services received 8/3/07, 8/6/07 and 8/8/07 and a unpaid bill from Medical Diagnostic Laboratories for services received 8/3/07 (Document #1).

A Notice of Decision informing Ms. Amy Carlimi of her Medicaid eligibility was mailed to her on August 9, 2007 (Document #2). This notice also informed Ms. Carlimi of her eligibility for retroactive reimbursement. Ms. Carlimi was informed that the deadline to submit her request for reimbursement was September 10, 2007. The address and contact number to the Reimbursement Unit was also given to call or write if there were questions or additional time was needed to submit a request. Ms. Carlimi did not contact the Reimbursement Unit with any questions or to request additional time.

Ms. Carlimi's request for reimbursement was denied because it was not filed timely. A Recipient Reimbursement Notice of Decision (Document #3) was mailed to her on October 1, 2007. Medicaid Eligibility Manual Policy G-2100 states that the enrollee is given 30 days to contact Medicaid to request consideration for reimbursement (Document #4).

On October 17, 2007 the Recipient Reimbursement Unit received Ms. Carlimi's request for an appeal dated 10/03/07 (Document #5). Ms. Carlimi indicated that she received the bills after the deadline date to submit her request for reimbursement to Medicaid. However, the invoice dates on the receipts from Center for Women's Health are 8/3/07 and 8/9/07. The invoice date for Medical Diagnostic Laboratories is 8/14/07and the invoice dates for Quest Diagnostics are 8/8/07, 8/9/07, 8/10/07, 8/14/07 and 8/15/07. Ms. Carlimi received notification of all these bills before the deadline date to submit her request to Medicaid for reimbursement which again was 9/10/07.

POLICY REFERENCES:

1. Medicaid Eligibility Manual G-2100

The BLANCHARD, ET AL V. FORREST court judgment requires the Agency to reimburse Medicaid recipients certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through the receipt of the initial medical eligibility card (MEC). The enrollee is given 30 days to contact Medicaid to request consideration for reimbursement. (Document #4)

RELATED DOCUMENTS:

1. Bills submitted for reimbursement (Document #1)
2. Louisiana Medicaid Program Notice of Decision(Document #2)
3. Notice of Recipient Reimbursement Decision (Document #3)
4. Medicaid Eligibility Manual Policy G-2100 (Document #4)
5. Appeal Request dated 12/21/06 (Document #5)

_____ _____

D.Davis Date
Program Specialist
(225)342-9045

_____ _____

Audrey Piper Date
Medicaid Program Manager 1-B
(225)342-3882

Provider not enrolled as a LA Medicaid Provider

SUMMARY OF EVIDENCE

IDENTIFYING INFORMATION:

Name: Susan R Czudek
Address: 1259 Rose Lee Lane
Leesville, LA 71446
Telephone #: (337)375-5337

I.D. #: 4747211756513
SSN: 439-67-1906
Docket #: Not Assigned

ACTION APPEALED:

Ms. Susan Czudek is appealing the rejection of his claim for Reimbursement through the Department of Health and Hospitals, Medicaid Reimbursement Section.

EXPLANATION OF ACTION AND APPLICABLE POLICY:

On October 27, 2008 Ms. Susan Czudek submitted a cashier's receipt dated 10/07/08 from Walmart Vision Center #0405(Document #1) to the Recipient Reimbursement Unit requesting reimbursement. On November 26, 2008 Ms. Doris Harris contacted Walmart Vision Center and was informed that they do not accept LA Medicaid.

According to Medicaid Policy G-2100, the agency must verify that the provider was an enrolled Medicaid provider on the date of service (Document #2). The request for reimbursement was denied and a Notice of Recipient Reimbursement Decision (Document #3) was mailed to Susan Czudek on December 3, 2008 explaining the denial.

The Notice of Decision (Document #4) dated October 15, 2008 mailed to Ms. Czudek informing her of Ariana Grant's eligibility for Medicaid also informed her of the requirements for reimbursement. The notice informs the enrollee that the bills must be for medical care, services, or supplies furnished by a provider who was enrolled in the Medicaid Program at the time of service. This information is found under Eligibility For Retroactive Reimbursements #3.

On December 15, 2008 our office received Ms. Susan Czudek's request for an appeal dated December 10, 2008 (Document #5).

POLICY REFERENCES:

1. Medicaid Eligibility Manuel G-2100: Blanchard Et Al vs Forrest

The BLANCHARD, ET AL V. FORREST court judgment requires the Agency to reimburse Medicaid recipients certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through the receipt of the initial medical eligibility card (MEC). To qualify for reimbursement, the following criteria must be met: The agency has verified that the provider was an enrolled Medicaid provider on the date the enrollee received service. (Document #2)

RELATED DOCUMENTS:

1. Cashier receipt from Walmart dated 10/07/08 (Document #1)
2. A copy of Policy Reference MEM G-2100 (Document #2)
3. Notice of Recipient Reimbursement Decision (Document #3)
4. Notice of Decision dated 10/15/08 (Document #4)
5. Appeal request signed by Susan Czudek dated 12/10/08 (Document #5)

_____ _____

D. Davis Date
Medicaid Program Supervisor
(225)342-9045

Disagreed with amt. reimbursed

SUMMARY OF EVIDENCE

IDENTIFYING INFORMATION:

Name: Arana A. Sonnier
Address: 2711 East Simcoe Apt 1
Lafayette, LA 70501
Telephone #: (337)237-1892

I.D.#: 4960844229376
SSN: 270-76-2067
Docket #: None Assigned

ACTION APPEALED:

Ms. Arana Sonnier is appealing the amount received on her claim for reimbursement through the Department of Health and Hospitals, Medicaid Reimbursement Section.

EXPLANATION OF ACTION AND APPLICABLE POLICY:

On December 1, 2006, the Retroactive Reimbursement Unit received from Ms. Arana Sonnier a statement from LA Oncology Associates for services received 09/06/06, a letter requesting reimbursement for services received 09/06/06 and a copy of your letter informing her of her eligibility for retroactive reimbursement (Document #1). The statement submitted from LA Oncology Associates indicated that Ms. Sonnier made a payment of $250.00 on 09/06/06. It also indicated that the charge for services for 09/06/06 was $86.00. The $164.00 remaining was applied to her account.

Reimbursement was considered for the payment of $86.00 made to LA Oncology Associates for an office visit (procedure code 99212) received on 09/06/06. The Medicaid rate for this procedure is $30.13 (Document #2). Medicaid Eligibility Manual Policy G-2100 states that recipients will be reimbursed at the Medicaid rate, less any Third Party Payments (Document #3). A Notice of Recipient Reimbursement Decision (Document #4) along with a check in the amount of $30.13 was mailed to Ms. Sonnier on December 15, 2006.

On January 18, 2006 our office received an appeal request from Ms. Sonnier dated 01/12/07. Ms. Sonnier stated "The total amount paid out of pocket was $250.00. I've enclosed itemized bills" (Document #5).

The Patient History Summary submitted indicated that only $86.00 was charged for services received 09/06/06. The remaining $164.00 was applied to services received 08/23/2006 at which time Ms. Sonnier was not eligible for Medicaid. Her Medicaid eligibility began 08/31/06. According to the Medicaid Eligibility Policy Manual to qualify for reimbursement, the enrollee has to eligible for Medicaid on the date of service (Document #3).

POLICY REGERENCES:

1. Medicaid Eligibility Manual G-2100

The BLANCHARD, ET AL V. FORREST court judgment requires the Agency to reimburse Medicaid recipients certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through receipt of the initial medical eligibility card or the reactivation of the medical eligibility card. A bill paid by the enrollee after receipt of the MEC or the reactivation of the MEC is not eligible for reimbursement (Document #3).

RELATED DOCUMENT:

1. Information received 12/01/06 from Ms. Arana Sonnier (Document #1)
2. Medicaid Rate for procedure code 99212 (Document #2)
3. Medicaid Eligibility Manual Policy G-2100 (Document #3)
4. Notice of Recipient Reimbursement Decision (Document #4)
5. Appeal Request dated 01/12/07 (Document #5)

_____ _____

D. Davis Date
Medicaid Program Specialist 2
(225)342-9045

_____ _____

K. McNabb Date
Medicaid Program Specialist Supervisor
(225)342-9322

Had MEC. It is not. was updated by enrollee.

SUMMARY OF EVIDENCE

IDENTIFYING INFORMATION:

Name: Rachel Lee
Address: 1212 Brokenbraugh Ct Apt B
Metairie, LA 70005
Telephone #: 504-874-4887

I.D.#: 0597898791813
SSN: 433-29-1135
Docket #: None Assigned

ACTION APPEALED:

Ms. Rachel Lee is appealing the rejection of her claim for reimbursement through the Department of Health and Hospitals, Medicaid Reimbursement Section.

EXPLANATION OF ACTION AND APPLICABLE POLICY:

On July 17, 2006, the Retroactive Reimbursement Unit received from Ms. Rachel Lee a cashier's receipt and prescription receipts dated June 13, 2006 from Walgreen Pharmacy (Document #1). The prescription receipts indicated that Medicaid denied payment because the recipient had other insurance on file.

When Ms. Rachel Lee applied for Medicaid on October 20, 2005 she reported she had insurance with Humana Health Plans (Document #2). This insurance was cancelled effective 12/01/05. However, the request to update this information was not made with Medicaid until 06/30/06 (Document #3).

One of the Rights and Responsibilities of Medicaid recipients is to tell Medicaid within 10 days of the following changes: 1) If anyone receiving health coverage moves out of state; 2) Changes in were they live or get their mail; and 3) Changes in other health insurance coverage (Document #2). According to Medicaid Eligibility Manual, Policy G-2100 (Document #4), bills paid after receipt of the initial medical eligibility card or the reactivation of the medical eligibility card are not eligible for reimbursement. Ms. Rachel Lee's request for reimbursement was denied.

Brooke Lee has been eligible for Medicaid since 10/01/2005. Her Medicaid eligibility card was issued on 10/31/05. A Notice of Decision was mailed to her on July 19, 2006 informing her of the denial (Document #5). On July 31, 2006 our office received a request for an appeal from Ms. Rachel Lee dated July 26, 2006 (Document #6).

POLICY REGERENCES:

1. Medicaid Eligibility Manual G-2100

The BLANCHARD, ET AL V. FORREST court judgment requires the Agency to reimburse Medicaid recipients certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through receipt of the initial medical eligibility card or the reactivation of the medical eligibility card. Bills paid by the enrollee after receipt of the MEC or the reactivation of the MEC are not eligible for reimbursement (Document #7).

RELATED DOCUMENT:

1. Bills submitted for reimbursement (Document #1)
2. Louisiana Children's Health Insurance Program Application (Document #2)
3. Medicaid Eligibility Determinations System - Third Party Liability Policy Maintenance Screen (Document #3)
4. Medicaid Eligibility Manual Policy G-2100 (Document #4)
5. Notice of Decision dated 07/19/06 (Document #5)
6. Appeal Request dated 07/26/06

_____ _____

D. Davis Date
Medicaid Program Specialist 2
(225)342-9045

_____ _____

K. McNabb Date
Medicaid Program Specialist Supervisor
(225)342-9322

Agency Reversal

March 26, 2002

Jamie B Tairov
14231 Cottingham Ct.
Baton Rouge, LA 70817

RE: Appeal Request
ID#'s: 2697147824102/437-37-5173
Docket Number: 0008684

Dear Ms. Tairov:

Upon notification of your request for an appeal and review of your case, our office has agreed to do an agency reversal. An error was made in identifying the date of service to Baton Rouge Clinic for Rebecca Tairov.

However, Baton Rouge Clinic is not a Medicaid Provider. Therefore we are unable to reimburse you for services received on 09/04/01 and 09/06/01.

A new notice has been sent to you regarding our decision. You do have the right to appeal this decision also. A hearing will not be scheduled at this time. If you have any questions, feel free to contact me at (225)925-3906.

Sincerely,

D.Davis, EE2

CC: Appeals Bureau

Agency Reversal

May 7, 2007

TO: Bridgett Robillard
6363 Djuwana Drive
Baton Rouge, LA 70811

RE: 8198331109306/433-43-9524
Docket No. – Not Assigned

Dear Ms. Bridget Robillard

Upon notification of your request for an appeal and review of your case, our office has agreed to do an agency reversal. However, additional information is needed to determine if you are entitled to reimbursement.

You indeed submitted receipts showing the amounts you paid to Lake After Hours, Walgreen Pharmacy and Dr. Tiffany Chevalier. However, you failed to provide verification of third party payment which was requested on the Recipient Reimbursement Verification Form dated March 15, 2007 (copy attached).

In order to process your request for reimbursement you will need to provide an Explanation of Benefits from your private insurance provider for services received from Lake After Hours (2/18/07) and Walgreen Pharmacy (2/8/07). You may provide the retail cost of the drug from Walgreen Pharmacy if you do not have an Explanation of Benefits. You also need to provide a copy of the bill or a written statement from Dr. Chevalier which shows the date of service, procedure and diagnosis codes, the amount billed, amount you paid and verification of third party payment.

This information is due in our office by 5/22/07. If you cannot provide the information by this date, you must contact our office at (225)342-9045 and we can give you extra time to mail it in. A hearing will not be scheduled at this time. If you have any questions, regarding this matter, you may contact me at 225-342-9045.

Sincerely,

D. Davis
Program Specialist 2

cc: Appeals Bureau

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

APPEALS DIRECTIVE

TO: Ms. Janice Buckley, Claims Processing, MMIS

FROM: Anne Bolner
Administrative Law Judge

RE: Appeal Hearing of: Roland Stroud
Docket Number: 00-24-466

Whether or not Appellant is entitled to reimbursement cannot be determined from the record presented. Appellant was hospitalized in 2002. Medicaid policy regarding retroactive reimbursement has been revised several times since 2002. The record does not establish that the policy relied upon by MMIS is necessarily the policy applicable to the case. The record also fails to provide other information necessary to the determination of whether Appellant is entitled to reimbursement.

The MMIS office must reinvestigate Appellant's reimbursement claim and issue a new notice with appeal rights to Appellant regarding its findings.

Please report your action in regard to this directive in the space below.

REPORT TO APPEALS BUREAU BY AGENCY REPRESENTATIVE

I received the above directive on 4/25/06 **and initiated proceedings to carry out the order on the** 9 **day of** May, **2006. The following action has been taken:**

Requesting EOB from the enrollee to verify what his private insurance paid on each in-patient hospital DAY.

5/9/06
Date

Janice Buckley
Duly Authorized Representative of MMIS

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF APPEALS
617 NORTH BOULEVARD • P.O. BOX 4183 • BATON ROUGE, LOUISIANA 70821-4183
PHONE #: 225/342-0443 • FAX #: 225/342-8773
"AN EQUAL OPPORTUNITY EMPLOYER"

Document #2
page 1

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

APPEAL DECISION

In the case of:

ROLAND STROUD

Claim for:
Reimbursement

Appeal Number :
0024466

Identification Number :
6382335626176/437602440

Filed: February 3, 2006

Heard: March 9, 2006

This appeal was filed by Mr. Roland Stroud (Appellant) in response to the denial of his request for reimbursement of $850.00 paid by Appellant to Iberia Medical Center in connection with medical liabilities incurred by Appellant when he was hospitalized form August 27, 2002, through August 29, 2002. A telephone hearing was conducted. The undersigned Administrative Law Judge participated from the Bureau of Appeals in Baton Rouge. Appellant represented himself and participated from his home in New Iberia. Ms. Janice Buckley, Program Specialist with the Claims Processing and Medicaid Recipient Reimbursement Office of the Medicaid Management Information System (MMIS) represented the position of the MMIS and participated from her office in Baton Rouge.

ISSUE

Did the Agency properly deny reimbursement of $850.00 in connection with medical liabilities he incurred during his August 27, 2002, through August 29, 2002, hospital stay because his insurance paid more than the Medicaid allowable amount on the claim?

MEDICAID POLICY[1]

G-2100 RETROACTIVE REIMBURSEMENT

The BLANCHARD, ET AL V. FORREST court judgment requires the agency to reimburse *the* Medicaid *enrollee* certified on or after February 15, 1995 for part or all of any medical expenses paid by them beginning three months prior to the month of application through receipt of the initial
Medical Eligibility Card **(MEC).**

To qualify for reimbursement, the following criteria must be met:

1) The *enrollee* was Medicaid eligible for the date of service.

2) The agency has verified that the provider was an enrolled Medicaid provider on the date the *enrollee* received service.

3) The bills must be for the period beginning three months prior to the month of application through receipt of the initial MEC or reactivation of the MEC. Reactivation of the MEC would take place when an *enrollee* of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program, the certification period is usually twelve months.

4) The *enrollee* has not received reimbursement from Medicaid, the Medicaid provider or received payment in full by a third party entity.

5) The medical bills must be for medical care, services or supplies covered by the program at the time the service was delivered.

6) The *enrollee* must provide proof of payment to BHSF. Bills which were paid in full by a third party (such as Medicare, an insurance company, charitable organization, family or friend) cannot be considered for reimbursement unless the *enrollee* remains liable to the third party. It is a requirement that continuing liability of *the enrollee* be verified.

Reissued February 13, 2006 ***G-2100***
Replacing November 29, 2005 ***Retroactive Reimbursement***
"ITALICS" Text Revised
Medicaid Eligibility Manual Application Processing

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[1] Note: Medicaid Policy regarding retroactive reimbursement has been revised several times between 2002 when Appellant was hospitalized and 2006, the time of his appeal.

Document #2
Page 3

SUMMARY OF THE EVIDENCE

On December 9, 2005, Appellant sought reimbursement for $850.00 he paid in connection with his hospital stay from August 27, 2002, through August 29, 2002. On January 12, 2006, Appellant was notified that his claim for reimbursement was denied because his insurance paid more than the Medicaid allowable amount. According to the notice sent to Appellant, Appellant's insurer paid $36,868.00 and Appellant paid $850.00. The denial of the request for reimbursement was appealed.

At the appeal hearing, Appellant pointed out that if he had not been insured at all, Medicaid would have paid for his medical expenses arising out of his hospitalization. Appellant suggested that if he initially had been found to be disabled issues of retroactive coverage could have been avoided. The MMIS representative supplemented the record with information showing that the maximum Medicaid would have paid for Appellant's hospital stay would have been $703.70 per day. As Appellant stayed in the hospital three days, and Medicaid would not have compensated on the day of discharge, the Medicaid Program Specialist argued that Medicaid would only have paid $1,407.40 for Appellant's hospital stay on August 27, 2002, through August 29, 2002.

FINDINGS OF FACT

The undersigned Administrative Law Judge has carefully considered the entire available and credible evidence and based upon a preponderance of the evidence makes the following findings of fact:

1. Appellant paid at least $850.00 towards medical liabilities he incurred during his hospital stay from August 27, 2002, through August 29, 2002. Appellant claimed reimbursement from Medicaid for the $850.00 he paid.

2. DHH's MMIS Office determined that Appellant's reimbursement claim met preliminary criteria for reimbursement consideration, but Appellant's reimbursement request was denied because the MMIS Office found that Appellant's insurance carrier had paid more than the Medicaid allowable rate.

3. Appellant's insurance provider paid $36,868.50 for Appellant's hospital care August 27, 2002 through August 29, 2002.

RECOMMENDATIONS AND CONCLUSIONS

The record presented does not provide sufficient information to determine whether Appellant's insurer paid more than the Medicaid allowable rate or whether or not Appellant is entitled to reimbursement.

Appellant was hospitalized in 2002. Medicaid policy regarding retroactive reimbursement has been revised several times since 2002. The record does not establish that the policy relied upon by MMIS is necessarily the policy applicable to the case.

The MMIS unit made its determination based upon Medicaid policy as stated in the February 13, 2006 revision: "***Reimbursements are made at the Medicaid rate, less any Third Party payments.***" **Medicaid Eligibility Manual G-2100.** Even assuming this policy is applicable, the record contains insufficient information to determine whether reimbursement should be made to Appellant. The record reflects a great discrepancy between what Appellant's insurer paid towards his August 27 through August 29, 2002, hospital stay, and what the MMIS representative said that Medicaid would have paid for Appellant's hospital stay. Appellant's insurer paid $36,868.50 for Appellant's hospital stay, while the MMIS representative argued that Medicaid would have only paid the per diem rate, a total of $1,407.40. The record suggests that the insurer paid for various medical procedures administered to Appellant while he was in the hospital. The record does not show what portion of the insurer's payment went towards expenses which would have been covered by Medicaid as per diem expenses. The record does not support that conclusion that Medicaid would only have paid the hospital per diem and would have paid nothing toward the medical procedures administered to Appellant in the hospital.

Whether or not Appellant is entitled to reimbursement cannot be determined from the record presented. The MMIS office must reinvestigate Appellant's reimbursement claim and issue a new notice with appeal rights to Appellant regarding its findings.

RECOMMENDED DECISION:

Whether or not Appellant is entitled to reimbursement cannot be determined from the record presented. The MMIS office must reinvestigate Appellant's reimbursement claim and issue a new notice with appeal rights to Appellant regarding its findings.

I hereby submit the foregoing report of the proceedings and my proposed decision and recommend its adoption as the decision of the Secretary of D.H.H.

Anne Bolner
Administrative Law Judge

Document #2
Page 8

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Bobby Jindal
GOVERNOR

Department of HEALTH and HOSPITALS
Alan Levine
SECRETARY

AUG 11 2008

Ms. Shirley J. Cosby-Hill
On behalf of Mable Jones
522 Patrick Street
Minden, LA 71055

RE: Mable Jones
Docket Number: 00-33-686
Identification Number: 6181809066523
Parish: Webster

Dear Ms. Cosby-Hill:

The attached decision has been adopted as a result of the Administrative hearing held on July 23, 2008. This decision exhausts any administrative remedy within this Department. If you are dissatisfied with this ruling, you have the right to seek judicial review in accordance with Louisiana Revised Statute 46:107(C).

Any request for judicial review must be filed in the 19th Judicial District, Parish of East Baton Rouge, or in the district court of the parish of the appellant's domicile within 30 days from the date of this letter.

Sincerely,

I. D. Trent
Director, Bureau of Appeals
On behalf of the Office of the Secretary
Department of Health and Hospitals

cc: Ms. Tamara Manuel, Medicaid Program Monitor, MMIS Unit;
Webster Parish Medicaid

RECEIVED
1 2008
CLAIMS PROCESSING

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Bobby Jindal
GOVERNOR

Department of
HEALTH and
HOSPITALS
Alan Levine
SECRETARY

APPEAL DECISION

In the case of:

Mable Jones

Claim For:

Recipient Reimbursement

Appeal Number:
00-33-686

Identification Number:
6181809066523

Filed: May 22, 2008

Heard: July 23, 2008

This appeal was filed on behalf of Ms. Mable Jones (Appellant) after the denial of a request for reimbursement of fees paid on behalf of Appellant for services received from February 17, 2008, through March 22, 2008, provided by Ms. Cindy Jones. A telephone hearing was conducted. The undersigned Administrative Law Judge participated from the Bureau of Appeals in Baton Rouge. Appellant was represented by her daughter, Ms. Shirley J. Cosby-Hill, who participated from the Region 7 Medicaid Office in Shreveport, along with Ms. Bennie Chase, R.N., a Medicaid Certification Specialist II; Ms. Sharon Orr, Medicaid Analyst II; Ms. Betty Stanley, Medicaid Area Manager, Region 7 Medicaid; Ms. Delmar Ayers, Direct Support Worker Supervisor, St. Genevieve Healthcare Service (a Medicaid service provider); Ms. Cindy Jones, a Personal Care Attendant; and Ms. Princetta Johnson, Support Coordinator for Easter Seals. Ms. Tamara Manuel, Medicaid Program Monitor for the Retroactive Reimbursement Unit; and Ms. Deborah Davis, Medicaid Program Supervisor for the Retroactive Reimbursement Unit, participated from their office in Baton Rouge.

ISSUE

Did the Agency properly deny reimbursement of fees paid to Ms. Cindy Jones on behalf of Appellant for services received from February 17, 2008, through March 22, 2008, on the grounds that Ms. Jones was not a Medicaid service provider?

OFFICE OF MANAGEMENT AND FINANCE • BUREAU OF APPEALS
617 NORTH BOULEVARD • P.O. BOX 4183 • BATON ROUGE, LOUISIANA 70821-4183
PHONE #: 225-342-0443 • FAX #: 225-342-8773
"AN EQUAL OPPORTUNITY EMPLOYER"

MEDICAID POLICY
MEDICAID ELIGIBILITY MANUAL

G-2100 RETROACTIVE REIMBURSEMENT

******

Bills Not Eligible for Reimbursement

******

- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.

******

SUMMARY OF THE EVIDENCE

On April 15, 2008, the Medicaid Retroactive Reimbursement Unit received a request for reimbursement for payments made to Ms. Cindy Jones for services rendered in February and March of 2008. The reimbursement request was denied on the grounds that the provider, Ms. Cindy Jones, was not enrolled as a Medicaid provider. The denial was appealed.

At the appeal hearing, Appellant's daughter presented the testimony of various witness showing that in January of 2008, Ms. Cindy Jones applied for employment with St. Genevieve Healthcare Service (St. Genevieve) and that Ms. Cindy Jones was officially hired by St. Genevieve, a Medicaid service provider, on March 23, 2008. The Retroactive Reimbursement Unit representatives stated that regardless of when Ms. Cindy Jones became an employee of St. Genevieve, payments made directly to Ms. Cindy Jones could not be reimbursed because Ms. Cindy Jones was not a Medicaid service provider. Appellant's daughter stated that while seeking Medicaid benefits for her mother, she was unable to obtain adequate information about Medicaid policy.

FINDINGS OF FACT

The undersigned Administrative Law Judge has carefully considered the entire available and credible evidence and based upon a preponderance of the evidence makes the following findings of fact:

1. Appellant sought retroactive reimbursement from the Medicaid program for payments made to Ms. Cindy Jones for services provided from February 17, 2008, through March 22, 2008.

2. Between February 17, 2008, through March 22, 2008, Ms. Cindy Jones was not a Medicaid service provider.

RECOMMENDATIONS AND CONCLUSIONS

Applicable Medicaid policy required the denial of Appellant's request for reimbursement.

Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program are not eligible for retroactive reimbursement by the Medicaid Program. **Medicaid Eligibility Manual G-2100, Retroactive Reimbursement**. There was no evidence that Ms. Cindy Jones was enrolled as a Medicaid provider at any time. Payments made directly to Ms. Cindy Jones were not eligible for reimbursement.

The record supports the denial of Appellant's request for reimbursement for the services of Ms. Cindy Jones.

RECOMMENDED DECISION:

IN FAVOR OF THE DENIAL OF THE REQUEST FOR REIMBURSEMENT FOR PAYMENTS MADE TO MS. CINDY JONES.

I hereby submit the foregoing report of the proceedings and my proposed decision and recommend its adoption as the decision of the Secretary of the Louisiana Department of Health and Hospitals.

Anne Bolner
Administrative Law Judge

EXHIBITS

Presented by the Retroactive Reimbursement Office:

1. Summary of Evidence with related documents.

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

APPEALS COVER MEMORANDUM

Date: _____

To: Mr. Ivory Trent, Director
DHH Appeals Bureau

From: _____, Medicaid Program Supervisor
DHH/BHSF/MMIS/Recipient Reimbursement

Re:

Appellant Name	Medicaid ID Number	SSN

DOCKET #: _____ **OR** ❒ **Docket # Not Assigned** **TYPE CASE**_____

❒ **INITIAL REFERRAL** ❒ **ADDITIONAL INFORMATION–INITIAL REFERRAL DATE:**_____

❒ **1.** The above referenced appellant requested a fair hearing:
- ❒ Verbally by telephone on _____ ❒ Verbally in person on _____
- ❒ In writing & hand delivered on _____ ❒ Via facsimile & received on _____
- ❒ By U.S. mail–
  Postmark Date: _____ (Attach Original Envelope) ❒ Postmark Not Retained or Illegible
  Date Stamped in Local Office On_____
- ❒ Directly to the Appeals Bureau, SOE Request received in local office on _____

❒ **2.** A copy of the **original** rejection/closure notice is attached.

❒ **3.** **Summary of Evidence** - Two copies of the SOE (three copies if the appellant has legal representation) and all related documents are attached. Please schedule the hearing at the following location:
_____

❒ **4.** **Benefits at Issue in Appeal** - ❒ have been continued ❒ have not been continued ❒ Not Applicable

❒ **5.** **Agency Reversal** - Appeal has been resolved in favor of the appellant - No loss of benefits and Summary of Evidence not completed.

❒ **6.** **Withdrawal** - Appeal request withdrawn by the appellant - signed statement including reason enclosed.

❒ **7.** **Request Not Timely** - Appeal request appears to have **not** been timely filed. **Please advise whether this Appeal will be dismissed or if we should proceed with preparation of the Summary of Evidence.**

❒ **8.** **Legal Representative** (IF APPLICABLE) Name:_____
Address:_____
Telephone #: (____)_____

❒ **9.** **Other** _____

Medicaid Program Monitor:_____
Telephone #: (____)_____

Supervisor: _____
Telephone #: (____)_____

APPEALS

GENERAL INFORMATION

The Bureau of Appeals was established to ensure that fair hearings are provided to applicants and enrollees who are adversely affected by a determination made by the Department of Health & Hospitals, Medical Vendor Administration (Medicaid).

Applicants and enrollees are informed in writing on the application form, renewal form, and decision notice of their right to a fair hearing. The BHSF Flyer - Fair Hearings http://bhsfonlinemanuals/mfm/Flyer%20Fair%20Hearings.pdf provides information about fair hearings and is available to the public upon request. Oral explanation by Medicaid Analysts is given about fair hearings in any contact or discussion when such explanation is appropriate, particularly in contacts concerning denials, rejections, terminations, or reduction of benefits. A person who exercises the right to a Fair Hearing is called a claimant.

The claimant may represent himself at the hearing or be represented by any authorized representative such as a friend, relative, legal counsel, or other spokesperson.

While a fair hearing is not a court procedure, the degree of formality has increased to comply with due process requirements of the Administrative Procedures Act. The following safeguards are necessary to accomplish a Fair Hearing. The claimant is:

- Provided with a written notice, explaining the reason for the action and citing the policy reference;
- Provided an opportunity to question Agency witnesses at the hearing;
- Provided an opportunity to present arguments and evidence orally;
- Provided an opportunity to appear with counsel;
- Guaranteed the presence of an impartial Administrative Law Judge;
- Guaranteed a decision based solely on the legal rules and the evidence offered as proof at the hearing or obtained subsequent to the hearing if agreed to by the parties; and

- Provided with a statement explaining the reasons for the decision of the Administrative Law Judge and indicating the evidence on which the decision is based.

Due process not only defines and protects the rights of the claimant, but also requires the Agency to observe principles of fair play in all contacts with claimants. In hearings, the Agency has the right to the essentials of fair play. Those rights are equal to those of the claimant in submitting evidence, examining witnesses, etc. The claimant has a duty to cooperate.

The Agency's primary goal in a fair hearing is to assure that the policy applicable to the claimant's situation is correctly applied. For this reason, the Agency must assist the claimant or authorized representative in filing and preparing his fair hearing request and help prepare his case for appeal, if necessary. The hearing process also provides a feedback mechanism whereby policy-making officials can determine if modifications to policies and procedures are needed.

DEFINITIONS

Adequate Notice: A written notice informing the enrollee of an action that has been taken at the time the notice is given. This notice also provides notice of the right to request a Fair Hearing within the appropriate time period.

Administrative Law Judge (ALJ): An impartial individual responsible for conducting a fair hearing and issuing a recommended decision on the issues in question.

Advance Notice: A written notice of adverse action mailed to the applicant or enrollee prior to taking the action. The notice provides an opportunity to rebut the decision or to appeal the proposed action.

Advance Notice Period: The ten-day period from the date of the notice to the date the proposed action will be taken. If the applicant or enrollee requests a fair hearing during the advance notice period, the action is not taken unless the applicant or enrollee specifically waives the right to continue benefits.

Adverse Notice: Any written notice informing the applicant or enrollee of any Agency action which unfavorably affects his case and the effective date of that action.

Agency: Any operating unit of the Medical Vendor Administration which includes the local, regional, or state office.

Agency Conference: A meeting between the claimant and the Agency where a supervisor or manager explains the action that is being appealed. It may be conducted by telephone if the claimant agrees. The Medicaid Analyst and/or Medicaid Program Specialist may participate if the supervisor deems this appropriate and the claimant is in agreement.

Agency Reversal: The issue is resolved in the claimant's favor by the Agency.

Appeal Decision: An official report which makes specific factual findings. It identifies pertinent state or federal regulations and gives the reason for the decision. It is the final written decision of the Department of Health and Hospitals on the issue in question.

Appellant: Person appealing the Agency's decision.

Authorized Representative: Any authorized person acting on behalf of an applicant or enrollee. This can be the claimant's friend, relative, attorney, paralegal, legal guardian, or any person the applicant/enrollee chooses. The authorized representative must be acting with the permission of the applicant or enrollee unless the application/enrollee is under an order of interdiction.

Benefits: Any kind of assistance or payments made by the Agency on behalf of the enrollee.

Bureau of Appeals: The office staffed by Administrative Law Judges who are responsible for facilitating hearings between the appellant and Agency.

Claimant: An applicant or enrollee who has requested a fair hearing.

Directive: A written communication from the Bureau of Appeals to the Agency giving specific instructions to be taken as a result of a hearing. This directive shall be executed within ten days and reported to the Bureau of Appeals within 14 days of the date of the directive or by the appeal's 90th day deadline, whichever is earliest.

Docket Number: A unique number that identifies a specific appeal.

Effective Date: The intended date on which a termination, a sanction, or reduction in benefits becomes effective.

Fair Hearing: An administrative procedure during which a claimant or authorized representative may present evidence to show why it is believed the Agency action, proposed action, or inaction is not fair and should be reversed.

Official Hearing Record: Official transcript summarizing what transpired at the hearing. It includes all evidence and other material introduced at the hearing, the recommendations of the Administrative Law Judge, and the directive, if issued.

Request for a Fair Hearing: Any clear expression, either oral or written, made by the claimant or authorized agent indicating the wish to appeal an Agency decision.

Rejection: Denial of an applicant's initial request for benefits; as no benefits have been awarded, advance notice of decision is inappropriate.

Reversal: A decision made by the Bureau of Appeals directing the Medical Vendor Administration to "reverse" its adverse action decision.

Subpoena: An order commanding a designated person or document to be present at a hearing.

Summary of Evidence: A document prepared by the Agency that states the reason for the action being appealed. Its purpose is to provide the claimant with information needed to prepare his case for the hearing.

Withdrawal: A decision made by the appellant to terminate the appeals process.

WHO CAN REQUEST A FAIR HEARING

Any applicant or enrollee who believes he has been adversely affected regarding benefits or services under any program administered by the Medical Vendor Administration may request a fair hearing.

The Bureau of Appeals has the right to deny a request for a fair hearing when:

- The request is outside of the jurisdiction of the Bureau of Appeals;
- The request for a hearing is made after the time limit has expired;
- The sole issue is one of state or federal law or regulation requiring automatic adjustment in benefits for classes of recipients; or

- The individual requesting the appeal is not the applicant, enrollee or person authorized to act on his behalf.

When a fair hearing request is accepted by the Bureau of Appeals, it may be disposed of without a hearing and without a decision if:

- The request for a fair hearing is withdrawn by the claimant;
- The claimant abandons his request for a fair hearing. If the claimant or his authorized representative fails to appear for a hearing and has made no contact with the Agency or the Bureau of Appeals, the request for a fair hearing will be considered abandoned. If he later requests to reschedule, the request will be evaluated by the Bureau of Appeals for good cause; or
- An Agency reversal decision is made prior to a hearing.

TIME LIMITS FOR FAIR HEARINGS

Requesting a Fair Hearing

When a decision is made on a case, such as a certification, rejection, change in benefits, or closure, the applicant or enrollee is notified and allowed 30 days from the date of the notice to request a fair hearing.

Agency Response

At any time the claimant, either orally or in writing, makes a request for a fair hearing to the Agency, the Agency must submit the request to the Bureau of Appeals within **seven calendar days of receipt**.

Rendering of a Decision

A prompt, definitive and final decision must be provided by the Bureau of Appeals within 90 days from the date of the fair hearing request. If the hearing is delayed at the request of the claimant or authorized representative, this time limit is extended for a period agreed to by both parties. The hearing cannot be delayed more than 30 days without good cause. The time limit for rendering a decision may be extended when the claimant wishes to present additional evidence. This time limit is extended for a period agreed to by both parties.

SPECIFIC RIGHTS OF A CLAIMANT

The claimant or authorized representative has the right to:

- Receive assistance from the Agency with filing and preparation;
- View specific case record documents or applicable policy necessary to determine whether a hearing should be requested and/or the documents or policy necessary to prepare for a hearing, without charge;
- Referral to available community legal services; http://bhsfonlinemanuals/portal/legalaidnumbers.pdf
- A verbal explanation of the hearing procedures in the native language of the claimant. If the claimant does not speak English, the Agency must provide interpreters who speak the appropriate language;
- Review the case record. Upon request and at a reasonable time before the hearing, the claimant or authorized representative must be allowed to review the claimant's case record or any documents to be used by the Agency at the hearing. Copies of these documents must be provided to the claimant upon request and without charge. The case record must be viewed in the presence of an Agency representative;
- Present the case in person or with the aid of others, including legal representation;
- Request that a subpoena be issued. The Bureau of Appeals will evaluate such requests and authorize the Agency to serve the subpoena, if appropriate;
- Request a postponement prior to the hearing. The Bureau of Appeals will decide if a postponement is to be granted based upon good cause;
- Submit evidence and bring witnesses to the hearing. The claimant has the right to advance arguments without undue interference and to question or refute any testimony or evidence. The claimant has the right to confront and cross examine witnesses; and
- Request a rescheduled hearing after failing to appear at the hearing. The Bureau of Appeals will evaluate the requests to determine if good cause exists.

BENEFITS PENDING THE FAIR HEARING DECISION

Generally, benefits must be continued or reinstated to the benefit level of the previous month if an applicant or enrollee requests a fair hearing prior to the expiration of the Advance Notice or within ten days of the date of the Adequate Notice. Exceptions to this rule are listed below:

- The applicant or enrollee indicates in writing he does not want benefits continued.
- A determination is made that the sole issue is one of an existing or change in state or federal law.
- A change unrelated to the appeal issue affecting the applicant or enrollee's eligibility occurs while the hearing decision is pending and the applicant/enrollee fails to request a hearing after receiving the notice of change.
- Reduction or termination as a result of a mass change.

Medicaid benefits will continue at the prior level until the end of the certification period or until the resolution of the hearing. The cost of any rendered Medicaid services or payments are subject to recovery by the Agency if its action is upheld.

AGENCY RESPONSIBILITY

Supervisory Review and Agency Conference

When the claimant or authorized representative requests a fair hearing or expresses dissatisfaction with an action, proposed action or inaction, a supervisor **and** the Medicaid Analyst must review the case record. Agency policy as well as specific case factors shall be reviewed.

The Agency may offer to hold an Agency conference, in person or by telephone, with the dissatisfied party in order to review the circumstances. This does not postpone the time frame for submitting a Summary of Evidence. The conference must be held within two working days of the request unless the claimant requests that it be held later. If the claimant cannot be reached by telephone, the Agency may send a letter within two days offering to hold a conference as soon as possible. A supervisor or manager may conduct the Agency conference. It may be conducted by telephone if the claimant agrees. A representative or other legal counsel may accompany the claimant. The Medicaid Analyst may participate if the supervisor deems this appropriate and the claimant is in agreement.

If the review or the conference reveals that the complaint can be resolved within Agency policy, the Agency must immediately correct the action. This must be confirmed with the claimant in writing. If the complaint cannot be resolved, the Agency must explain the appeals procedures, the manner in which the claimant may be represented, and what specific issues might be settled in a fair hearing.

Preparation of the Appeals Packet

The complete packet should be mailed to:
Bureau of Appeals
P. O Box 4183
Baton Rouge, LA 70821-4183

The packet must be double sealed if it contains Federal Tax Information (FTI); that is one envelope within another envelope. The inner envelope should be marked "confidential" with some indication that only the designated official or delegate is authorized to open it.

Federal Tax Information includes information obtained through SIEVS Option B, and information/completed forms returned from the financial institution, insurance company or employer that was derived from information obtained from SIEVS Option B.

NOTE: IRS information is also accessible through Option L if you have been granted access to IRS information (Option B).

Information obtained from SOLQ, LAMI, LDET, The Work Number, etc. is not considered FTI.

1. Preparation of the Appeals Cover Memorandum

Complete and submit an Appeals Cover Memorandum (available on the BHSF Online Manuals at http://bhsfonlinemanuals/forms/covermem.pdf) which specifies or includes:

- The method by which the fair hearing was requested (e.g. verbally, in writing and hand delivered, by mail, etc.). When the request is received by mail, the original envelope* must be routed to the Bureau of Appeals with the request;

***The postmark is used to establish the file date. When the envelope is not included, it is impossible to properly establish the file date with any degree of certainty.**

- Whether benefits are being continued at the level prior to the request (for certified cases);
- The name, address, and telephone number of the claimant's legal representative, if applicable;

  Note: If claimant has legal representation, notify Michael Coleman MColeman@dhh.la.gov, Medicaid Eligibility's representative in the DHH Bureau of Legal Services.
- The hearing location (usually the parish Medicaid office); and

  Note: Indicate on the Appeals Cover Memorandum if the claimant cannot attend the hearing at the local Medicaid office or if a face-to-face hearing is needed with the Administrative Law Judge (ALJ). (Example: It may be necessary for the ALJ to view the extent of a claimant's disability).
- Any other information needed to complete the Appeals Cover Memorandum.

2. Preparation of the Summary of Evidence

Prepare and submit a Summary of Evidence unless:

- The request for a fair hearing is not made within the time limits specified in applicable policy;
- The claimant withdraws the request; or
- The complaint is resolved within Agency policy; the Agency has corrected the action and has confirmed this with the claimant in writing. A copy of the written confirmation shall be submitted to the Bureau of Appeals.

The Summary of Evidence is an important document in the appeals process. Its purpose is to provide information necessary to the claimant or his authorized representative in preparing for the hearing. It should be easy to read and understand. Abbreviations, acronyms, and terminology that may be unfamiliar to the claimant should be avoided. The claimant should be referred to by name rather than "the client", "the applicant", "the recipient", or "the enrollee". Agency actions being appealed should be explained in concise statements with precise references to policy and

appropriate documents.

The original and one copy of the Appeals Cover Memorandum, Summary of Evidence, and all documents referenced must be submitted to the Bureau of Appeals. If the claimant has legal representation, an additional copy of the Summary of Evidence must be submitted to the Bureau of Appeals. One complete copy of the packet shall be scanned into the Electronic Case Record (ECR) and be retained in the Agency record. All correspondence sent to and received from the Bureau of Appeals shall be scanned into ECR.

The use of a "fill in the blank" or "standard" Summary of Evidence form is allowable provided that all required information is included and all information contained in the Summary pertains to the issue being appealed.

Summary of Evidence Format

The Summary of Evidence must be typewritten, labeled on top, and signed and dated at the bottom. Do not use Agency letterhead.

Summary of Evidence Content

Identifying Information

This section must show the claimant/appellant's name, MEDS case identification number, Docket number, if known, and the Social Security Number. If a decision notice is not attached, the claimant's address must also be included.

Action Appealed

This section must show the following information.

- Basis of the claimant's appeal (closure, rejection, changes in benefits, failure of Agency to act, etc.);
- Medicaid Programs considered;
- General reason for the Agency's action;
- Effective date of the action; and
- Status of the claimant's benefits. If benefits are continued at the same level

because the applicant/enrollee appealed within the advance notice period, this fact must be stated.

Explanation of Action and Applicable Policy

This section must concisely state the reason for the Agency action, and cite the policy authorizing this action by specific reference number. This section should blend with the documents section so details are not unnecessarily repeated. Emphasis must be placed on citing facts and their impact. Case activity should be detailed in chronological order as they occurred. Procedural aspects of obtaining the facts should not be given unless needed for relevance to eligibility or actions taken (Example: failure to cooperate).

Related Documents

This section must list all documents relevant to the action under appeal. Each document should be identified by its official name (rather than by a form number), date, and relevance. The copies of the documents are to be labeled on the bottom right corner of the document with the word "exhibit" and number, such as Exhibit #1.

If relevant to support the decision of the Agency, include the Case Activity Log (CAL) from the ECR. Do not use the CAL if it is redundant of other information being submitted.

The decision notice must always be included. The most recent application or renewal form must be included. When a telephone renewal or ex parte was conducted and there is no renewal form, include the CAL entries.

The Agency notice on which the appellant requested a fair hearing must be included.

Special Considerations in Preparing Summary of Evidence

The Summary of Evidence for certain type cases must have additional information included as follows.

1. Disability Cases

The *Explanation of Action* must include the reason medical records from current sources were obtained. (Example: Mr. Smith stated he is not receiving regular medical care. Therefore, an examination with Dr. Farrell Curtis was arranged. This is the only current medical information available.) A statement must be included that the adverse action is based on the Medical Eligibility Determination Team's (MEDT) decision. The date of the decision and MEDT's

comments must be included.

The *Related Documents* section must include:

- The decision notice;
- All current and prior medical reports, social information, and disability decisions; and
- The most recent application or renewal form.

Failure to submit all current and prior information regarding medical reports, social information, and disability decisions may result in a decision in favor of the claimant. If the claimant is represented, two copies of all medical reports must be included and the statement, "Copy of all medical and social information on which the disability decision is based is attached." must be shown in the list of documents.

If the claimant is not represented, one copy of all medical reports must be included. Each medical report must be itemized and list:

- The name of the doctor or facility;
- The date of the report; and
- The status of the individual doctors, such as treating physician. (Example: Reports from Dr. Jean Jones, treating physician, dated February 14, 2007 and September 26, 2007. Report from Dr. Mei Smith, Orthopedist, dated October 11, 2007.)

Any other relevant documents on which the incapacity decision was based, such as written decisions from the Social Security Administration, etc. must be listed, and the appropriate number of copies included.

2. Rejected Applications

The *Explanation of Action* section must include the date of application, reason for the denial, dates of any previous periods of certification, and dates of any prior rejections or closures.

3. Closures

The *Explanation of Action* section must include the date first certified, and, if apparent, how the physical and social conditions have improved since certification.

4. Closures or Benefit Amount Based on Budgeting Factors

The *Explanation of Action* section must identify the persons included in the income unit, i.e., Mr. and Mrs. Broussard and their two children. If a reduction or closure is involved, the factor that has changed must be included.

In the *Related Documents* section, in addition to the decision notice, the last application or renewal form (or CAL entries if a telephone renewal of ex parte were done), the budget worksheet and the income verification must be included.

5. Recovery

The *Related Documents* section must include:

- Notice(s) sent by the Fraud and Recovery section, including any proof of the amount to be recovered;
- BHSF Form TPL/MR (Enrollee Recovery Referral);
- Verification of the factor(s) causing ineligible benefits (income, resources);
- Budget worksheets showing correct budgeting procedures (required when unbudgeted income is involved);
- Application forms; and
- Any other pertinent documents.

CLAIMANT OPTS TO MAKE REQUEST DIRECTLY TO THE BUREAU OF APPEALS

If the claimant prefers to mail the fair hearing request directly to the Bureau of Appeals, provide the address, FAX and email address of the Bureau of Appeals http://dhhinet01/Omf/Appeals/Index.htm and inform the claimant what must be included. Inform the claimant that the copy of the notification letter should be used to send the request and that a

copy will be returned to him by the Bureau of Appeals.

Carefully advise the claimant of the time limit for submitting the request. The advance notice period must be stressed, if applicable. In these instances, the request date will be the postmark date on the envelope. The Agency will be contacted by the Bureau of Appeals within seven (7) calendar days when the request is received. The proposed action must be taken by the Agency if there has been no contact from the Bureau of Appeals by the end of the advance notice period.

Upon notification from the Bureau of Appeals of the receipt of a request for a fair hearing, the case record must be reviewed promptly in the local office by someone in a supervisory capacity to determine if adjustments are necessary. The claimant may be contacted as soon as possible to offer an Agency conference. If an action, proposed action, or inaction was incorrect, the error must be immediately corrected. The claimant must be notified in writing and a copy of this notification, along with the Appeals Cover Memorandum, must be sent to the Bureau of Appeals.

LOCAL MEDICAID FIELD OFFICE RESPONSIBILITY PRIOR TO HEARING

Administrative Controls

Administrative controls must be maintained to ensure that the Agency acts promptly upon receipt of a request for a fair hearing. Each local office must maintain a central tracking system recording receipt of all fair hearing requests including:

- Requests made in writing when the applicant or enrollee visits the local office;
- Written requests received by mail, FAX or e-mail;
- Requests expressed orally when the applicant or enrollee visits the local office;
- Requests expressed orally over the telephone; and
- Requests forwarded from the Bureau of Appeals.

Each fair hearing request must be recorded within one working day of receipt. Each entry must show the following information:

- Date of receipt of the fair hearing request;
- Last date the appropriate response is due to the Bureau of Appeals (within seven

calendar days of receipt of the request); and

- Claimant's name, MEDS case number, docket number (if known), and Social Security Number of the head of the household.

Once the request is logged, a tracking system must be in place to monitor the preparation of the Summary of Evidence and its timely submission to the Bureau of Appeals.

Reporting Changes

Once the fair hearing process begins and until a decision is rendered, the Agency must report changes in the claimant's circumstances to the Bureau of Appeals. If a change in benefits or a closure (for a reason other than the issue in appeal) is proposed, a copy of the notice must be sent to the Bureau of Appeals. The Agency must promptly report to the Bureau of Appeals any address change or other changes in circumstances which might affect the necessity of the Fair Hearing. (Example: The claimant has applied for both SSI/SSA benefits. A denial notice based on disability is received from the SSA Office after the appeal has been filed.)

The Agency must report changes to the Bureau of Appeals by memorandum prior to the hearing being scheduled, by telephone after the hearing has been scheduled, or by memorandum after the hearing has been held.

Postponement Requests

If a claimant or his authorized representative requests a postponement of the hearing, inform the claimant that only the Bureau of Appeals can grant this request. The Agency should relay the postponement request to the Bureau of Appeals on behalf of the claimant unless the claimant requests that he directly contact the Bureau of Appeals. The Bureau of Appeals will notify all interested parties of the rescheduled hearing date if granted.

Withdrawals

The claimant may withdraw his request for a fair hearing at any time prior to the hearing. The Agency must notify the Bureau of Appeals using the Appeals Cover Memorandum if the claimant exercises this right.

It is not appropriate for the Medicaid Analyst or supervisor to suggest that the appellant withdraw a Fair Hearing request. The claimant may withdraw his request at any time in writing. The written withdrawal should clearly state the reason that the appeal request is being withdrawn. It is acceptable for the Medicaid Analyst to assist in the preparation of this statement.

If a withdrawal is requested after the Summary of Evidence has been submitted, indicate the date that the Summary of Evidence was submitted on the Appeals Cover memo. A statement indicating the written withdrawal will be forwarded upon receipt **is not** acceptable.

Witnesses and Documents

The Agency must arrange for witnesses or documents when testimony or a document is considered necessary and material to the case without being unduly repetitious of other evidence. When the Agency's action has been based on verbal collateral contacts, these persons must attend the hearing to substantiate the Agency's action.

If the presence of a witness or a document cannot be arranged voluntarily, the Agency will submit a request for a subpoena to the Bureau of Appeals. The Administrative Law Judge (ALJ) will evaluate requests and authorize the Agency to serve the subpoena, if appropriate, and may independently decide on the need to issue a subpoena.

Preparation for the Hearing

The Agency representative is expected to present and document the Agency's case. This requires a complete knowledge of the case situation and a review of applicable regulations and policies. A conference between all involved Agency personnel may be held to prepare for the appeal. When clarification is required, such assistance must be sought without delay.

Evidence

The following types of evidence are listed in the order of importance.

- Sworn testimony of a person's direct knowledge of a situation.
- Written Verification - Critical information is obtained from the claimant or authorized representative.
- Oral Verification - Oral statements are given no weight if they are disputed by the claimant. Statements attributed to unidentified sources should not be mentioned. If a person has given information used in the Agency decision being appealed, that person should attend the hearing to present direct evidence and be cross examined by the claimant or his authorized representative. The claimant or his authorized representative has the right to cross examine witnesses.

To avoid delays or duplication, the Medicaid Analyst must organize all written and oral evidence

and plan for its presentation. The ability to effectively present the Agency's case in a professional way will be enhanced by organization and preparation.

BUREAU OF APPEALS RESPONSIBILITIES

The Bureau of Appeals has the sole responsibility for accepting or rejecting all requests for a fair hearing in accordance with applicable rules, state statutes, and federal regulations. The Bureau of Appeals must acknowledge fair hearing requests made directly to that office by or for a claimant, or requests submitted by the Agency. All requests must be denied or accepted in writing. The Agency and the appellant will be sent appropriate notification.

Scheduling

The Bureau of Appeals will schedule all fair hearings. The claimant, authorized representative and the Agency will be notified at least ten days in advance of the time, place, and date of the hearing. Hearings will be scheduled during regular business hours and will normally be set in the Agency's office, unless there are reasons for scheduling in another location.

Providing a Summary of Evidence to Claimant

The Bureau of Appeals will provide the Summary of Evidence to the claimant and to the authorized representative with the notice of the scheduled fair hearing.

Postponements

The Bureau of Appeals grants hearing postponements. All postponement requests must be directed to the Bureau of Appeals. The decision to postpone a hearing is based on good cause.

If a postponement has not been arranged with the Bureau of Appeals and the claimant does not attend the hearing, the appeal will be dismissed and the proposed action taken. The Bureau of Appeals may later determine that the claimant had good cause for missing the hearing. In such cases, the benefits will be continued or reinstated if action on the case was taken as a result of non-attendance. The Agency must be notified of all decisions regarding these matters.

Directive

If the Bureau of Appeals rules in favor of the claimant, the Agency will receive a Directive from the Bureau of Appeals. The Directive shall be executed within ten days and reported to the Bureau of Appeals within 14 days of the date of the Directive or by the appeal's 90th day

deadline, whichever is earliest.

List of Appeals Templates for C-related and D-related (not LTC) and Agency Reversal Letter

Coming Soon - The "clickable" documents will be listed here.

RR User Manuel

LOUISIANA
Department of
HEALTH and
HOSPITALS

UNISYS

Louisiana Medicaid Management Information System (LMMIS)

Recipient Reimbursement Application User Manual

LIFTs 2956 3061 3336 3340 4644

October 31, 2007

Prepared By
Technical Communications Group

UNISYS and the Louisiana Department of Health and Hospitals

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PROJECT INFORMATION

Document Title	Louisiana Medicaid Management Information System (LMMIS) – Recipient Reimbursement Application User Manual	
Author	Technical Communications Group, Unisys LMMIS QA	
	Revision History	
Date	**Description of Change**	**By**
September 19, 2005	LIFTs 2956 & 3061	Technical Communications Group
December 1, 2006	LIFTs 3336 & 3340; updated 5.2, 5.18 & 5.19	Cheryl Stickney
January 30, 2007	5.18 and footers	Cheryl Stickney
February 12, 2007	Updated 5.12, 6.0, 6.3, & 6.4	Cheryl Stickney
October 31, 2007	Major overhaul throughout in preparation for LIFT 4644; corrected usage errors and redundancies (corrected ubiquitous comma errors, "checkbox is checked" changed to "checkbox is selected", etc.); obscured PHI; replaced inappropriate use of future tense with present tense. Updated screen shots in 2.0. For LIFT 4644 (NPI): Updated 4.1, 4.3, 5.1, 5.3, 5.4, 5.5, 5.5.1, and 5.5.2. Added 5.5.3. Updated 5.17, 5,18, 6.2, 6.4, 8.0.	Randy Sheehan

TABLE OF CONTENTS

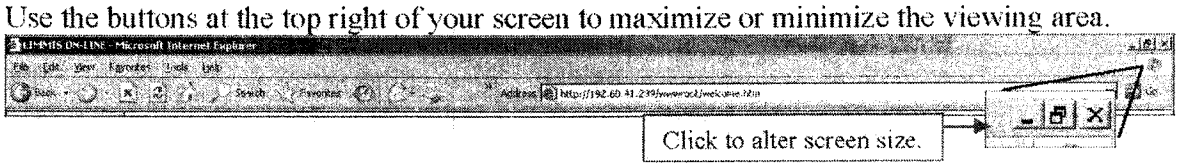
Welcome to the intranet based Recipient Reimbursement application. As defined in the 'Blanchard verses Forrest' decision, the Recipient Reimbursement Intranet System allows Department of Health and Hospital (DHH) to process out-of-pocket expenses to recipients incurred during their retroactive Medicaid eligibility period.

1.0 Getting Started - Hints and Tips

The following section contains some hints and tips to consider before using the application.

1.1 Internet Explorer

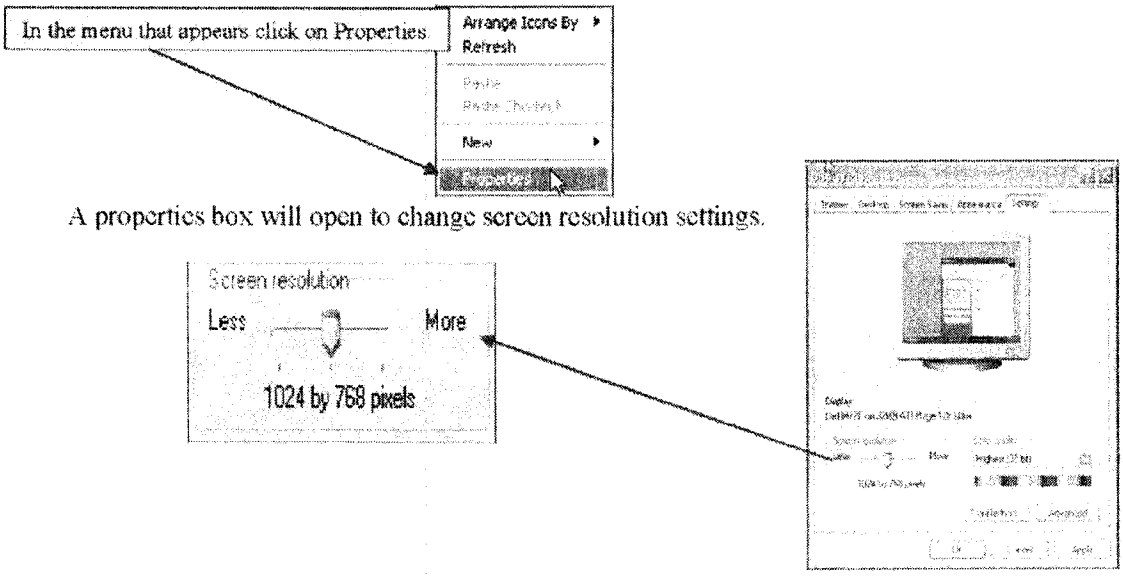
Because this is a web intranet application your internet browser will still be displayed at the top of your screen. However, these buttons should not be used to navigate through the application. DO NOT USE THE BACK BUTTON. This could cause errors and it should only be used when necessary.



1.2 Screen Resolution

This application has been specifically designed to fit as well as possible on a monitor with a screen resolution of 1024 x 768 pixels. The instructions that follow may vary depending on different versions of software.

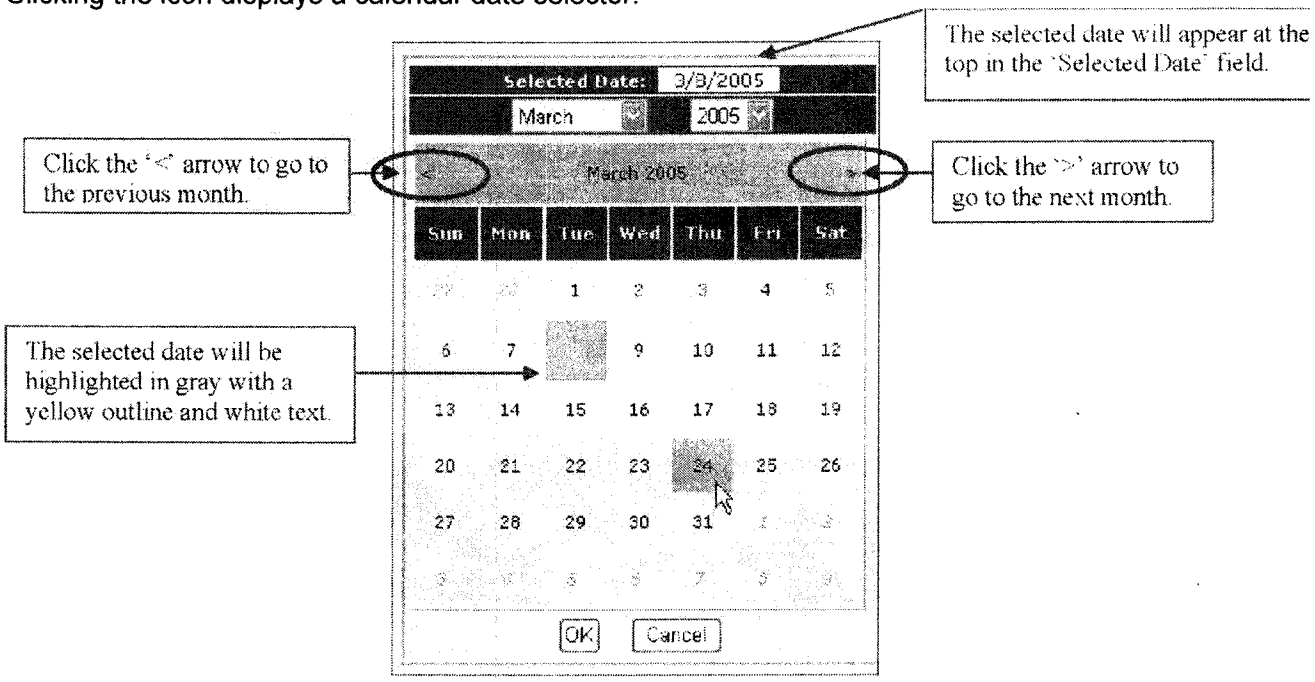
If your screen resolution is not set to this, it can easily be changed in Display Properties. On your desktop right click on any open/empty space.



1.3 Calendar pop-ups

Next to the textboxes that require a date range, a popup calendar is available to choose dates. The calendar is indicated by the following icon:

Clicking the icon displays a calendar date selector.



As you scroll over the dates the date are highlighted in gray but are not chosen until clicked. If you open the calendar and no date is selected, clicking the **OK** button does not populate the date fields. If you select a date and click the **Cancel** button, no date is populated.

Note:

- *The date fields are not populated until a date is selected and the **OK** button is clicked.*

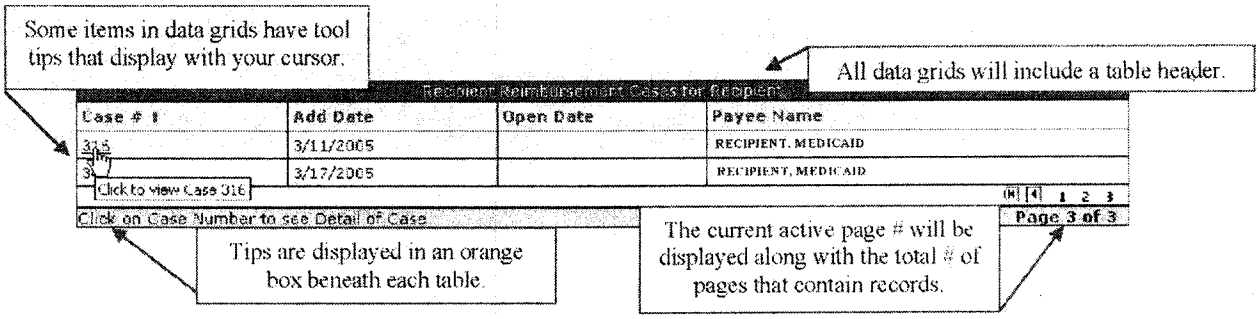
1.4 Print Page

Each screen features a **Print Page** link in the bottom right-hand corner.

Most of your screen should print nicely in the print default page orientation of portrait. However due to the width of the screen when entering claims for a request it is best to change your printer setting for page orientation to landscape view. For MOST computers access this after clicking the Print Page link under Preferences.

1.5 Data Grid Tables

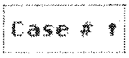
Sets of records are displayed in a table called a data grid.



1.5.1 Column Sorting

Some columns can be sorted. If a column can be sorted, the column heading is underlined, like a hyperlink, when your mouse passes over the column heading.

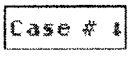
To sort, click on the column heading you wish to sort by and the table of records is sorted in ascending order.



A column sorted in ascending order is indicated by an up arrow:

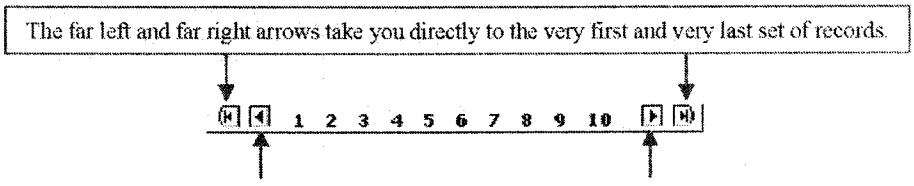
Clicking a column heading a second time in a row re-sorts the data in descending order by that column heading.

A column sorted in descending order is indicated by a down arrow:



1.5.2 Record Navigation

When more than 10 records are displayed, the records are listed on more than one page and navigation buttons are displayed to enable you to move between records.



1.6 Checkboxes

Checkboxes enable the user to select items or to answer a yes or no question.

- They are initially blank:

- Checkboxes are activated by clicking to enter a check.
- Clicking on a selected box again will set it back to blank, and the associated record will no longer be selected.

Note:

- *It is possible to have more than one checkbox selected at the same time.*

1.7 Radio Buttons

Similar to checkboxes in the way they work (see above), radio buttons are used as indicators.

- They are initially blank.
- They are activated by clicking to enter a dot.

- Unlike checkboxes, you cannot deactivate a radio button by clicking on it.
- You must choose an alternative radio button to highlight, and then the original one will no longer be chosen and will be set back to blank.

Note:

- *It is not possible to have more than one radio button in the same group selected at the same time.*

1.8 Text

Important text is displayed in bolded red font.

Case # 328			
Case Parish:	**Not Available**		
Recipient Name:	RECIPIENT, MEDICAID		**Reimbursement Period:**
Recipient ID:	NNNNNNNNNNNNN		
Recipient DOB:	**01/01/1971**		
Recipient Address:	**0101 Medicaid Road**		**7/1/2004 thru 1/31/2005**
Recipient Phone #:	**Medicaid, LA 70000-0000**		
Application Date:	**9/22/2004**		
Payee Name:	RECIPIENT, MEDICAID	Payee Phone #:	(111)111-1111
Payee Address:	0101 Medicaid Road Medicaid, LA 70000-0000		

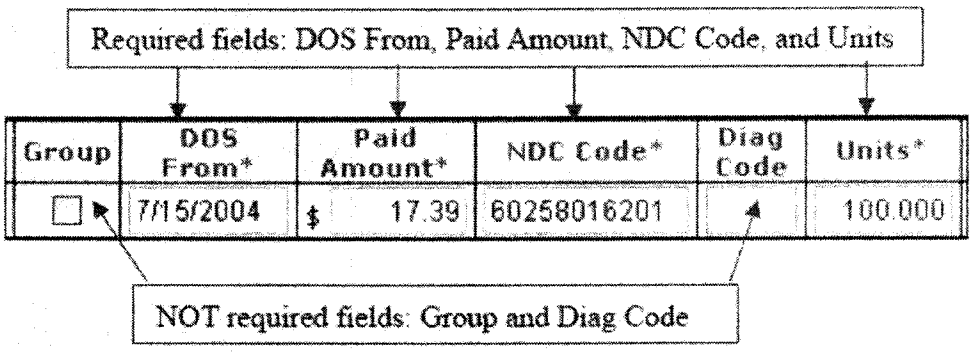
1.8.1 Payee Info Required Fields

When entering Payee information for a case, certain fields are required. These fields are designated by labels in red, bold font.

Payee First Name:	MEDICAID	Payee Last Name:	RECIPIENT
Payee Address1:	0101 MEDICAID	**Payee Phone #:**	1111111111
Payee Address2:			
Payee City:	MEDICAID	Payee State: LA	Payee Zip Code: 70000-0000

1.8.2 Claims Required Fields

For claim entry, certain fields are required. The required fields are designated by an asterisk mark to the right of the column name.



Note:

- *The '$' need not be entered anywhere in the application.*

1.9 Dates

Dates should be entered in the following format:

dd/mm/yyyy – for example '1/21/1971' meaning January 21st 1971.

The date example above includes the forward slash character ('/' – as in '**1/21/1971**'); you must type the slash into the date entry box.

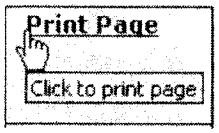
1.10 Tool Tips

Tools tips explains user interaction features in the application.

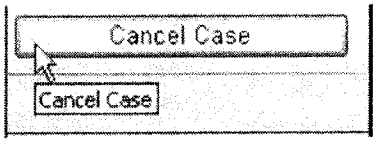
1.10.1 Links and Buttons

All links and buttons display tool tips with a mouse scroll over. Most links are displayed in blue and appear underlined with a mouse scroll over.

Links



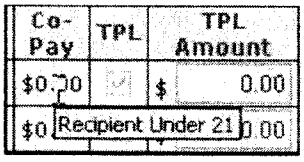
Buttons



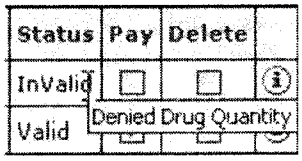
1.10.2 Data Grid Tables

However, only some data grid tables have records that display tool tips. In this case the tool tip displays with a mouse scroll over but shows as a cursor and not a pointer.

Co-Pay



Claim Status

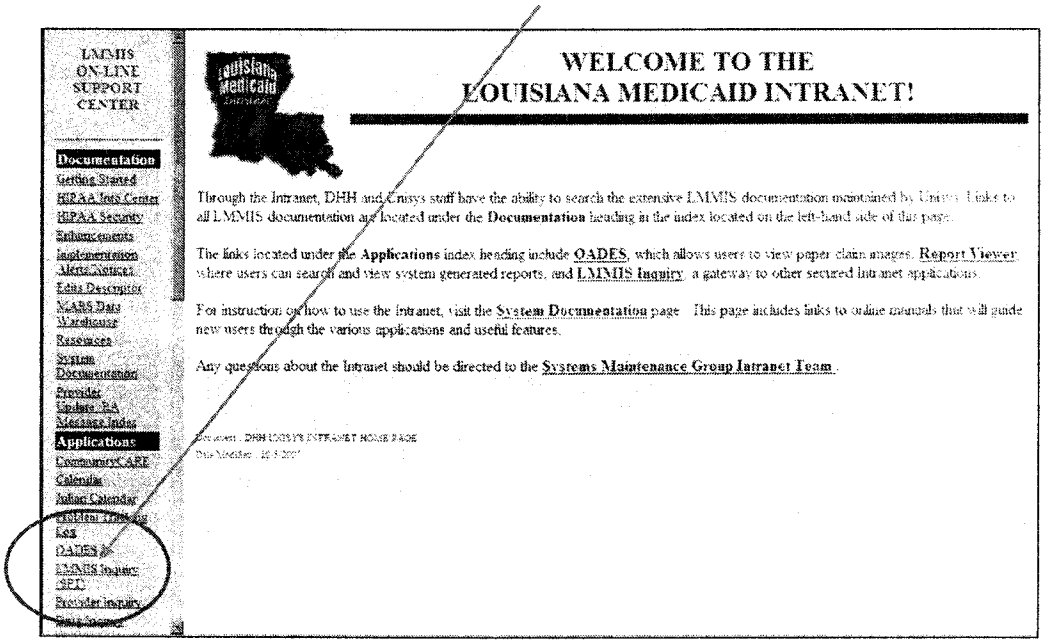


2.0 Login

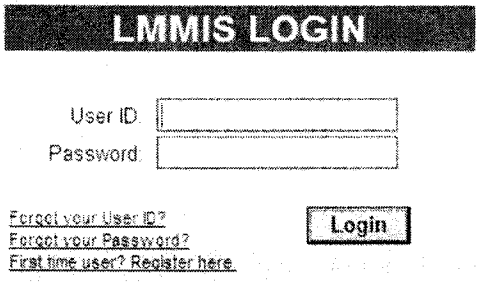
The user must first login into the LMMIS Inquiry (SPT) application before any actions can be taken.

2.1 Logging Into the Intranet Application

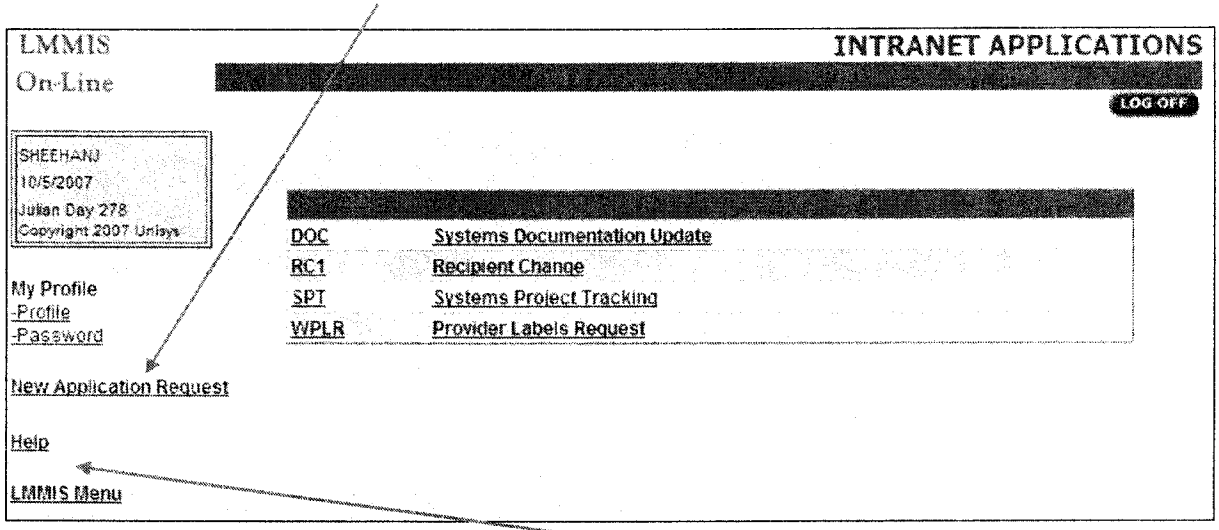
From the Intranet Homepage, Click the **LMMIS Inquiry (SPT)** link on the left navigation bar.



Login with LMMIS Intranet Login and Password. To find out a forgotten login or password, click **Forgot your User ID?** or **Forgot your Password**, as appropriate. To request a LMMIS Intranet Login ID, click **First time user? Register here**.



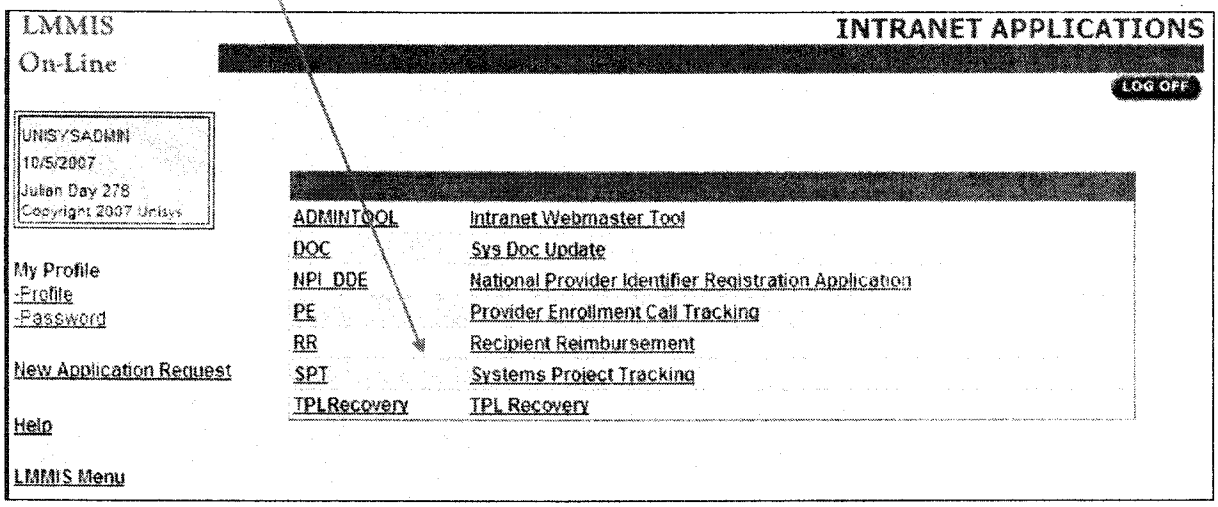
Once you have successfully logged in to the LMMIS Inquiry (SPT), a list of applications to which you have access is displayed. If RR (Recipient Reimbursement) is not among them, click on the **New Application Request** link to request access.



For additional help in requesting a new application, click the **Help** link.

2.2 Recipient Reimbursement Application Link

After logging in, the screen displays all of the applications to which the user has access. Choose the **RR Recipient Reimbursement** link to continue.



3.0 User Roles

3.1 Data Entry

The Data Entry user has the following capabilities:

- View all case details and letters
- Add note to any case
- Enter/Edit/Delete Claims to assigned case
- Search

3.2 Program Specialist

The Program Specialist user has the following capabilities:

- View all case details and letters
- Add new case
- Add note to any case
- Edit assigned case
- Enter/Edit/Delete Claims to assigned case
- Generate letter(s) for cases assigned to them
- Complete assigned case
- Cancel assigned case
- Request/Void Check to assigned case
- Cancel Request or Void to assigned case
- Search
- View the following reports:
  - Monthly Status Report
  - Pending Application Report
  - Weekly check request report
- Pharmacy vs. Professional Amts by Date Range

3.3 Administrator

The Administrator has all of the user privileges so far enumerated plus the following capabilities:

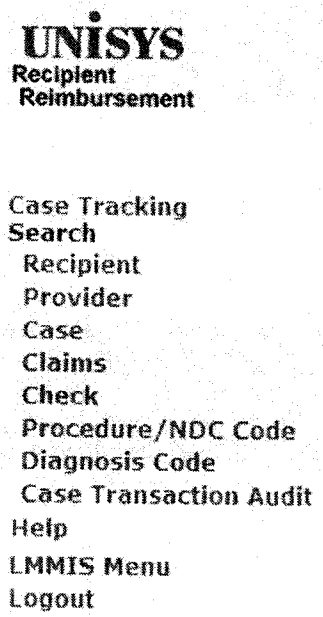
- Re-assign cases
- Change a case status from Open to Added
- Approve/deny checks
- Modify configurable application amounts
- Can view the following reports:
- Statistical Case Amount Paid vs. Requested by Date Range
  - No. Cases & Amount of Request by Date Range
  - Average Turnaround Time
  - Average Work Time

4.0 Data Entry

In the event that DHH requires Unisys to key in pharmacy claims, certain Unisys staff must be granted access to the Recipient Reimbursement application. The data entry user role accommodates this requirement.

4.1 Navigation

All Data Entry user roles have the following navigation options:



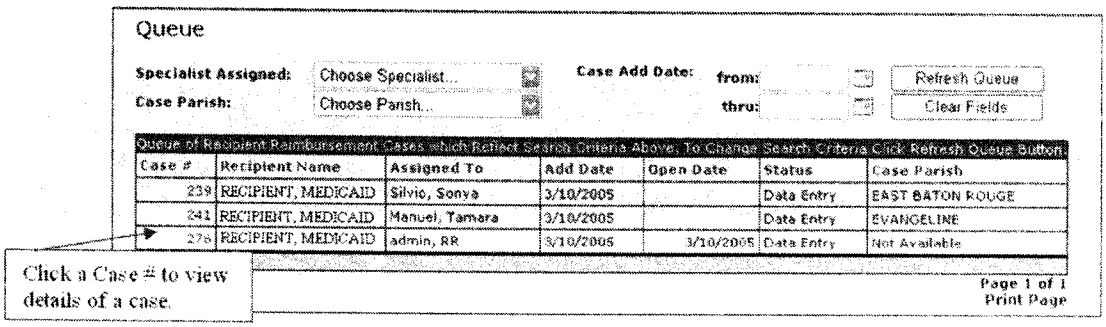
Case Tracking – click to display dropdown menu items
- **Queue** – takes user to Queue of Recipient Reimbursement Cases with optional search criteria.

Search – click to display dropdown menu items
- **Recipient** – opens Recipient Search Screen in popup window.
- **Provider** – opens Provider Search Screen in popup window.
- **Case** – opens Case Search Screen in popup window.
- **Claims** – opens Claims Search Screen in popup window.
- **Check** – opens Check Search Screen in popup window.
- **Procedure/NDC Code** – opens Procedure/NDC Code Search in popup window.
- **Diagnosis Code** – opens Diagnosis Code Search Screen in new popup window.
- **Case Transaction Audit** – opens Case Transaction Audit Search Screen in popup window

Help – opens in a new window with a User Manual.
LMMIS Menu – navigates to the LMMIS Intranet Applications home page
Logout – logs user out of the system and returns to the LMMIS home page.

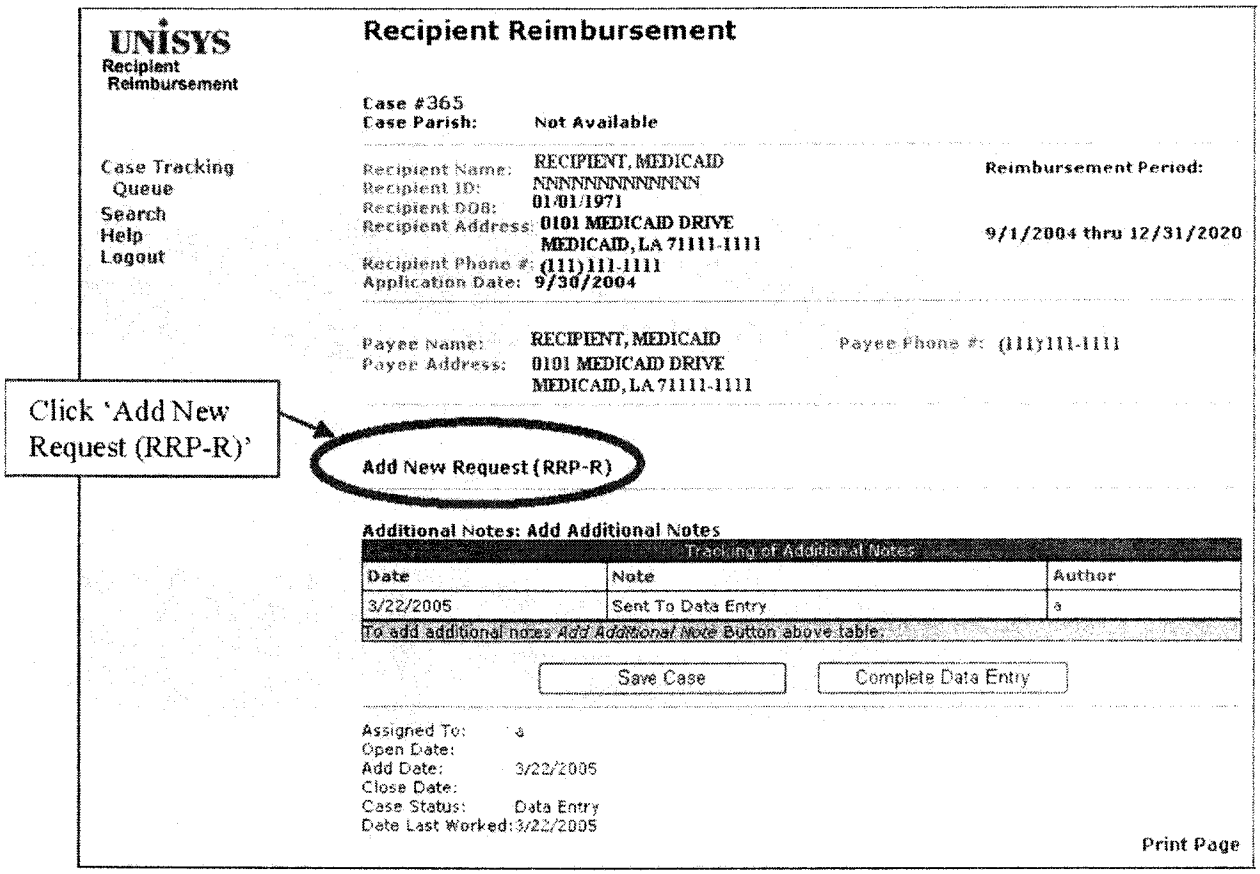
4.2 Data Entry Queue

The Data Entry Queue loads all cases that are in data entry status by order of case date descending. The list can be sorted and filtered by the user to find a case.

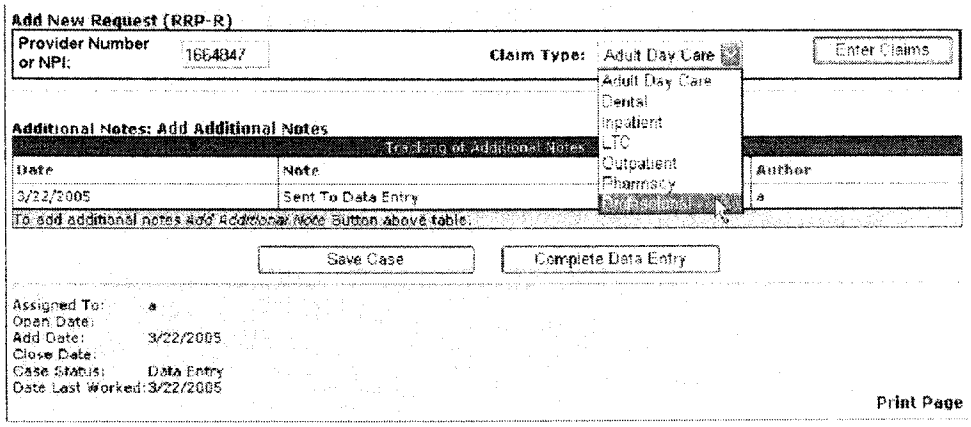


4.3 Case Detail Screen – Data Entry

When Data Entry opens a case, all case information and information for claims which have already been entered are shown. This screen can be used to enter multiple requests (RRP's) for a case by clicking the **Add New Request (RRP-R)** link.



The Data Entry Worker enters a Provider Number or NPI and selects the type of claim. Based on claim type selected, an entry form is displayed for entering claims.



Each claim type features a separate group of fields for claim entry:

Adult Day Care Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

Dental Claim
Group, DOS From, TOS, Paid Amt, Proc Code, Tooth Num, Surface, Diag Code, Units

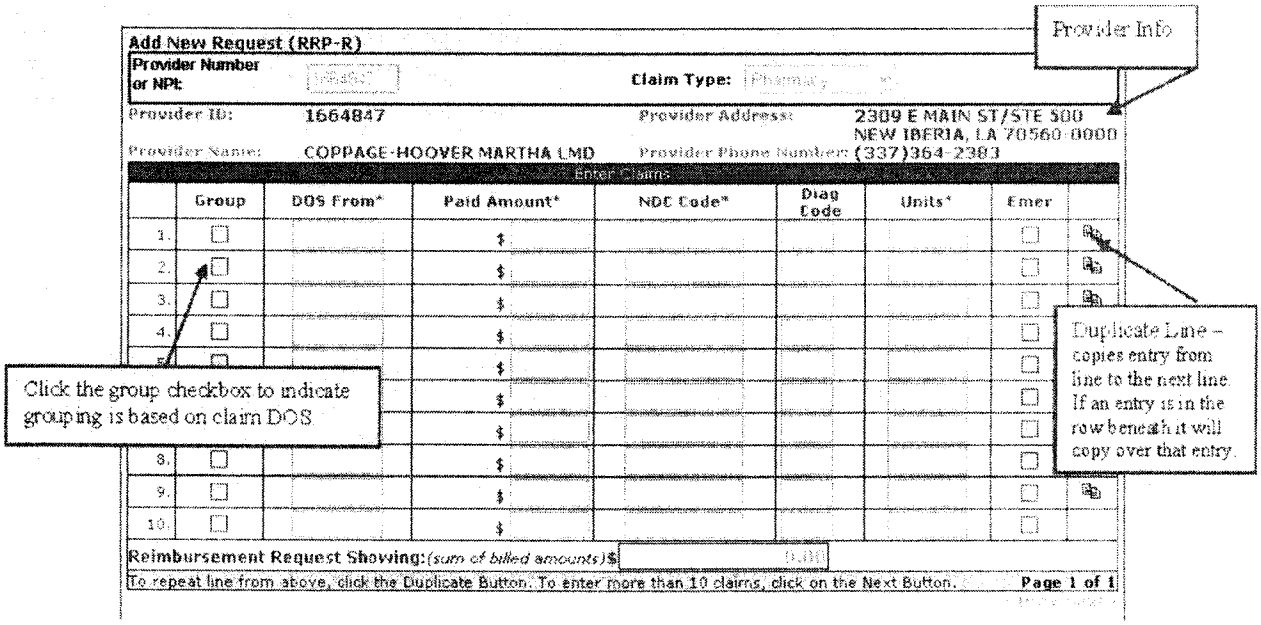
Inpatient Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

LTC Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

Outpatient Claim
Group, DOS From, TOS, Paid Amount, Proc Code, Diag Code, Units

Pharmacy Claim
Group, DOS From, Paid Amount, NDC Code, Diag Code, Units, Emergency

Professional Claim
Group, DOS From, TOS, Paid Amount, Proc Code, Diag Code, Units



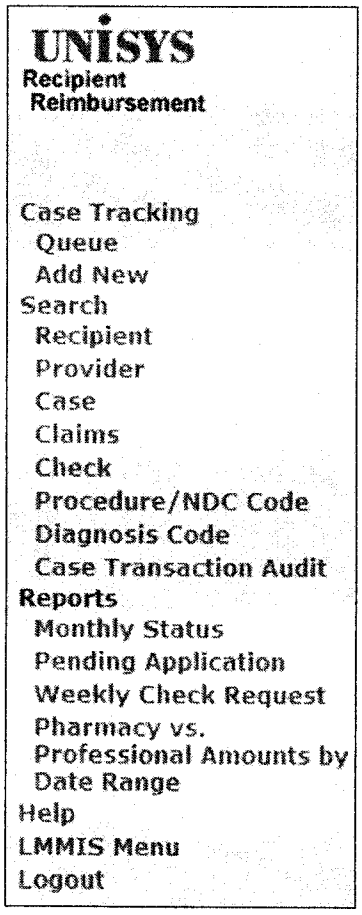
Notes:

- *Price Override, Pay, and Delete options are not available for Data Entry.*
- *After clicking **Complete Data Entry**, the case is removed from Data Entry Queue.*

5.0 Program Specialist

5.1 Navigation

All Program Specialist and Administrator user roles have the following navigation options:



Case Tracking – click to display dropdown menu items
- **Queue** – takes user to Queue of Recipient Reimbursement Cases with optional search criteria.
- **Add New** – takes user to Case Entry Screen to add a new Recipient Case.

Search – click to display dropdown menu items
- **Recipient** – opens Recipient Search Screen in popup window.
- **Provider** – opens Provider Search Screen in popup window.
- **Case** – opens Case Search Screen in popup window.
- **Claims** – opens Claims Search Screen in popup window.
- **Check** – opens Check Search Screen in popup window.
- **Procedure/NDC Code** – opens Procedure/NDC Code Search in popup window.
- **Diagnosis Code** – opens Diagnosis Code Search Screen in new popup window.
- **Case Transaction Audit** – opens Case Transaction Audit Search Screen in popup window

Reports – click to display dropdown Report menu. Select one to create a report.
- Monthly Status
- Pending Application
- Weekly Check Request
- Pharmacy vs. Professional Amounts by Date Range

Help – opens in a new window with a User Manual.
LMMIS Menu – navigates to the LMMIS Intranet Applications home page
Logout – logs user out of the system and returns to the LMMIS home page.

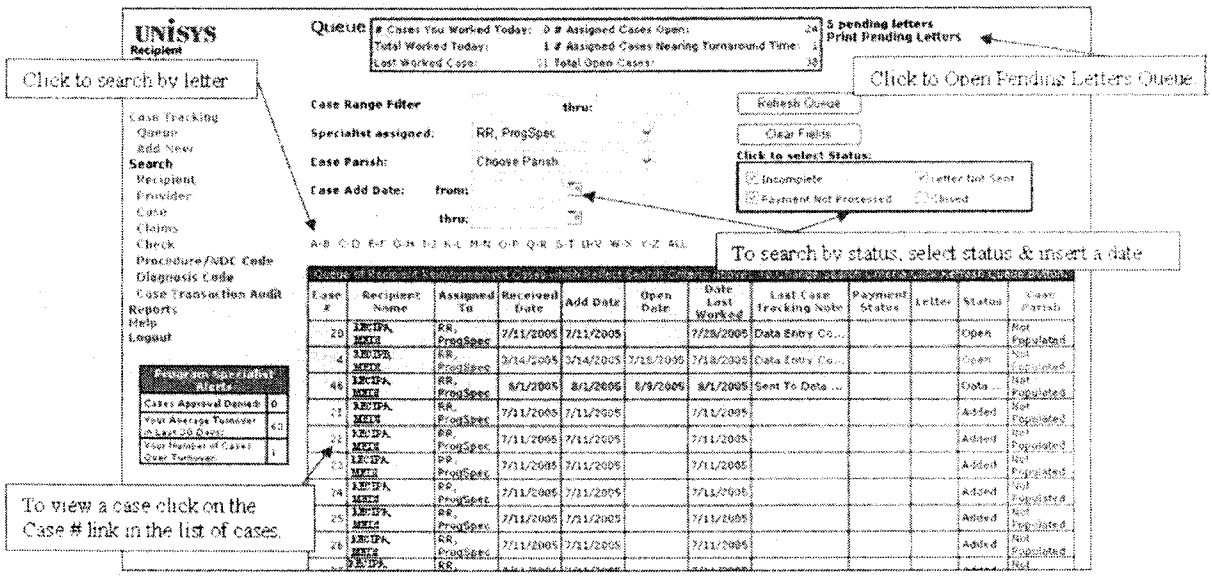
5.2 Queue

The Case Tracking Queue enables a Program Specialist to manage cases. The list defaults to all cases assigned to the current user which need work. The queue results can be modified by changing sort options at the top and clicking the **Refresh Queue** button. Newly assigned cases are displayed in green text.

Program Specialist Statistics

# Cases You Worked Today:	1	# Assigned Cases Open:	8
Total Worked Today:	11	# Assigned Cases Nearing Turnaround Time:	0
Last Worked Case:	269	Total Open Cases:	39

- **# Cases you worked today** – # of cases user logged in has worked today.
- **Total worked today** – # of cases all users have worked today.
- **Last worked Case** – Links to the case last worked by Specialist logged in.
- **# Assigned Cases open** – # of currently open cases assigned to the user logged in.
- **# Assigned Cases nearing Turnaround Time** – # of open cases assigned to the user that are in the system over the configurable turnaround time.
- **# Total open Cases** – # of open cases in the system for all users.



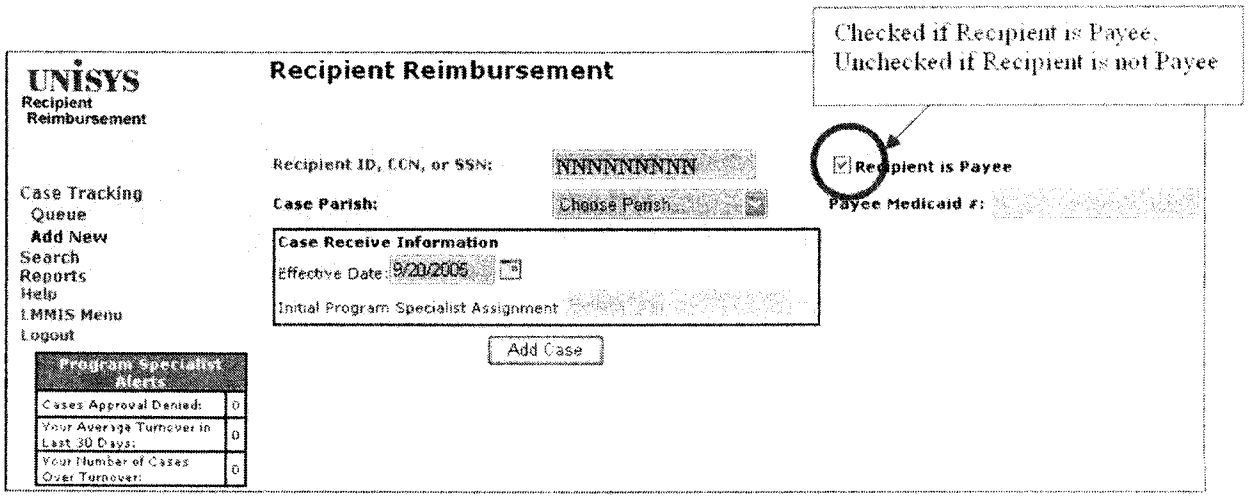
Program Specialist Alerts

Program Specialist Alerts	
Cases Approval Denied:	0
Your Average Turnover in Last 30 Days:	1
Your Number of Cases Over Turnover:	0

- **Cases Approval Denied** – All cases where the last check action on a case has been denied, until the action is cancelled by the user to show acknowledgement.
- **Your Average Turnover in Last 30 days** – Average number of days that every case that the current Program Specialist has closed in the last 30 days was open.
- **Your Number of cases over Turnover** – Number of cases for the Program Specialist logged in that are currently over the Configured Turnover limit.

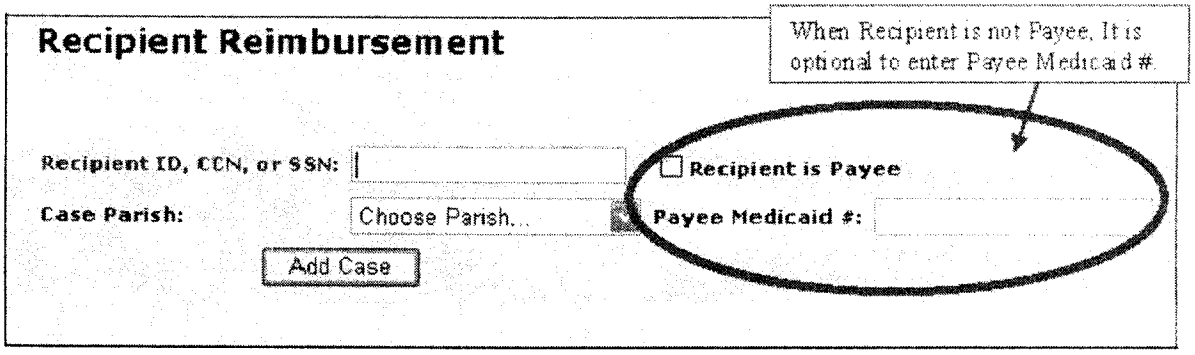
5.3 Add a New Case

From the Navigation menu, expand Case Tracking and click on the dropdown **Add New**. The Case Entry Screen opens and enables you to enter a Recipient ID.



At this point the case status is "Added".

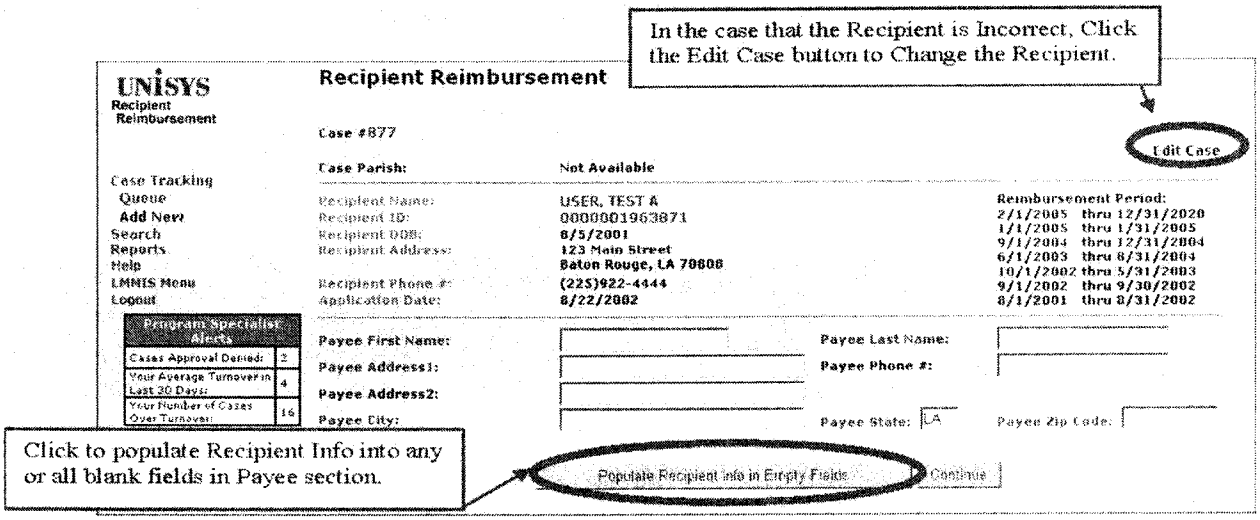
If the recipient is the payee, leave the **Recipient is Payee** checkbox selected. Otherwise, uncheck the **Recipient is Payee** checkbox. Choose a Parish and click the **Add Case** button.



At this point the case status is "Added".

5.4 Enter Payee Information

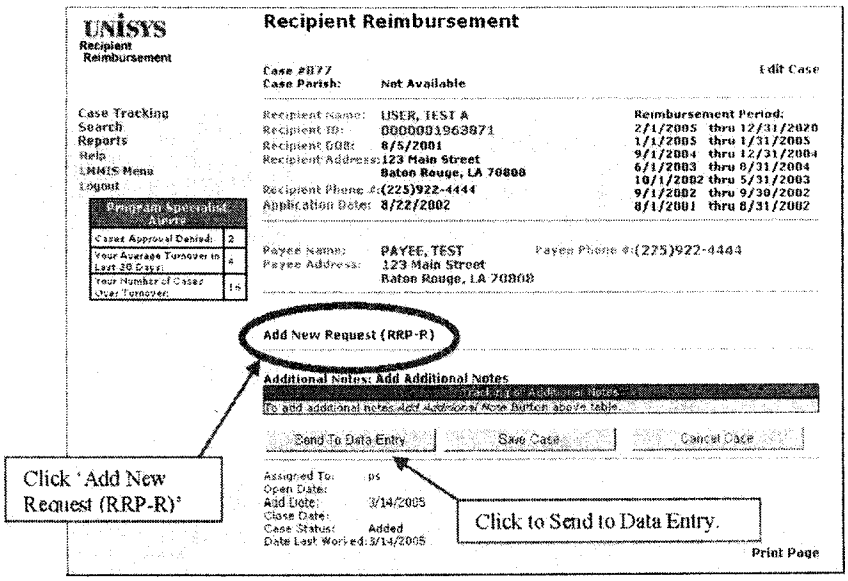
If the **Recipient is Payee** checkbox is not selected, the user must enter the payee information. Click the **Continue** button when done.



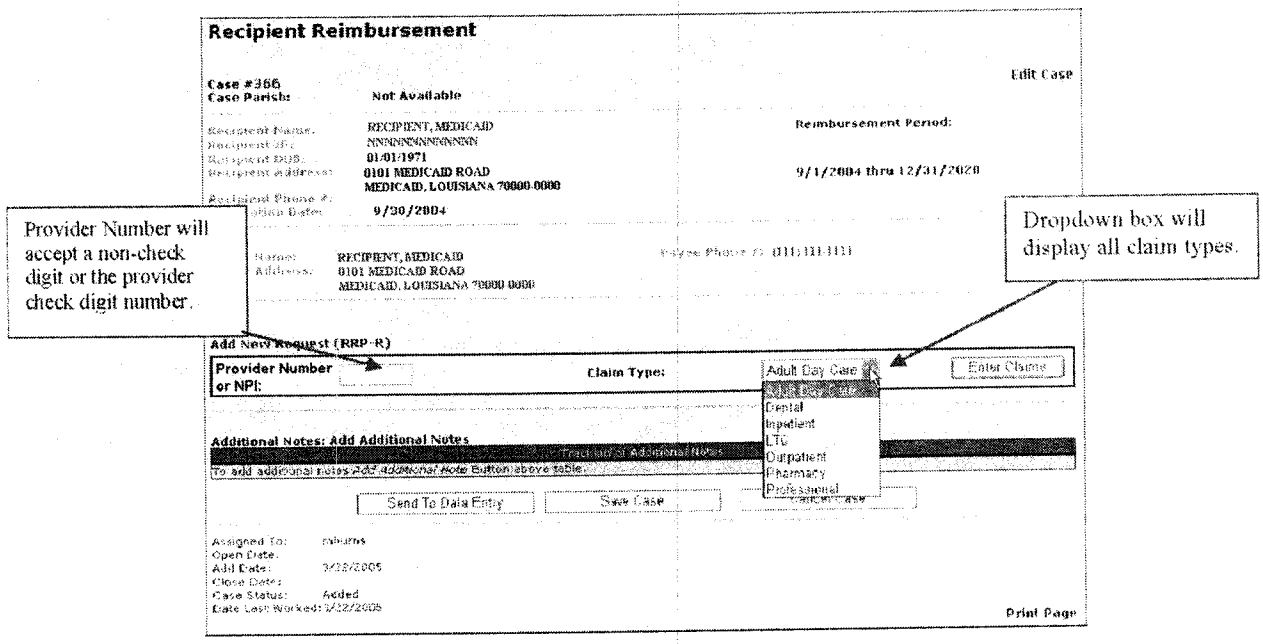
If the recipient and payee have similar information, type in the Payee information that differs from the Recipient information and click the **Populate Recipient Info in Empty Fields** button.

5.5 Add New Request

Once the recipient information is verified and all payee information is entered, a claim request can be added or the case can be sent to Data Entry.

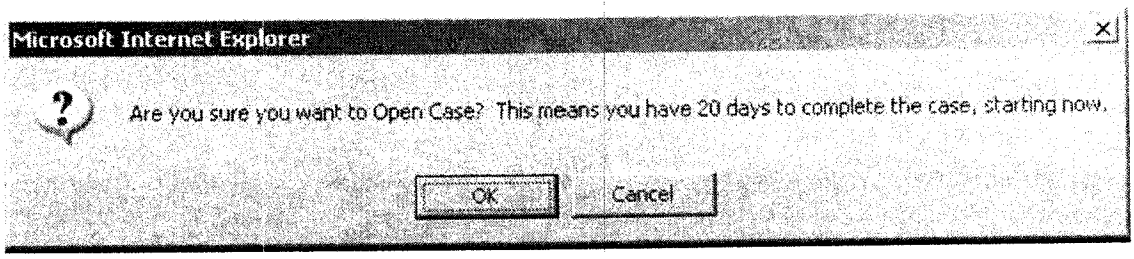


To begin entering a Request, enter a Provider Number or NPI and choose a Claim Type in the drop down list box. Click the **Enter Claims** button.



5.5.1 *Valid Provider ID*

Click on the **Enter Claims** button and enter the correct Provider ID or NPI and Claim Type. The following alert is displayed:



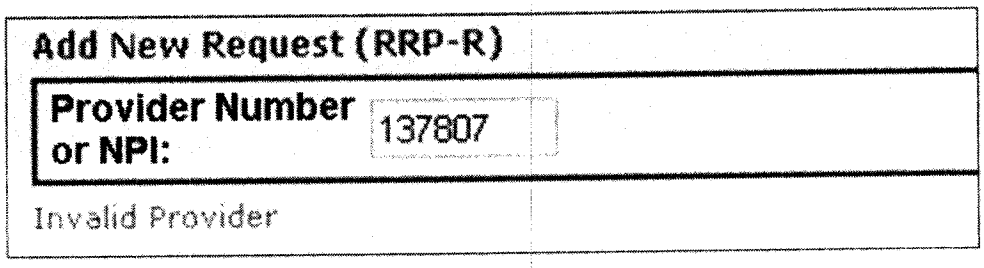
Notes:

- *This alert is displayed only for a case that has NOT yet been opened.*
- *The number of days allowed for an Open Case to be completed is a value that is configurable by Administrators; the default amount is 20 days.*

If the **OK** button is selected, the case status becomes "Open" and a Claims Entry form is displayed. If the **Cancel** button is selected, the case status stays "Added" and Claims cannot be entered.

5.5.2 *Invalid Provider ID*

If an incorrect Provider ID is entered and Claim type after clicking the 'Enter Claims' button, the following will be displayed:



Enter a new Provider Number or NPI and start over.

5.5.3 Multiple Provider IDs With Same NPI

If multiple Provider IDs have the same NPI Number, then the user is required to enter Provider ID (not NPI).

5.6 Claims Entry

An entry form based on the Claim Type selected in the dropdown menu is displayed. All Claim Types have the following checkbox options: Group, TPL, Pay, & Delete. In addition, each Claim Type provides the capability to enter a TPL Amount and a Price Override. An icon to duplicate a row to the next line is also provided.

Each claim type has separate fields for claim entry:

Adult Day Care Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

Dental Claim
Group, DOS From, TOS, Paid Amount, Proc Code, Tooth Num, Surface, Diag Code, Units

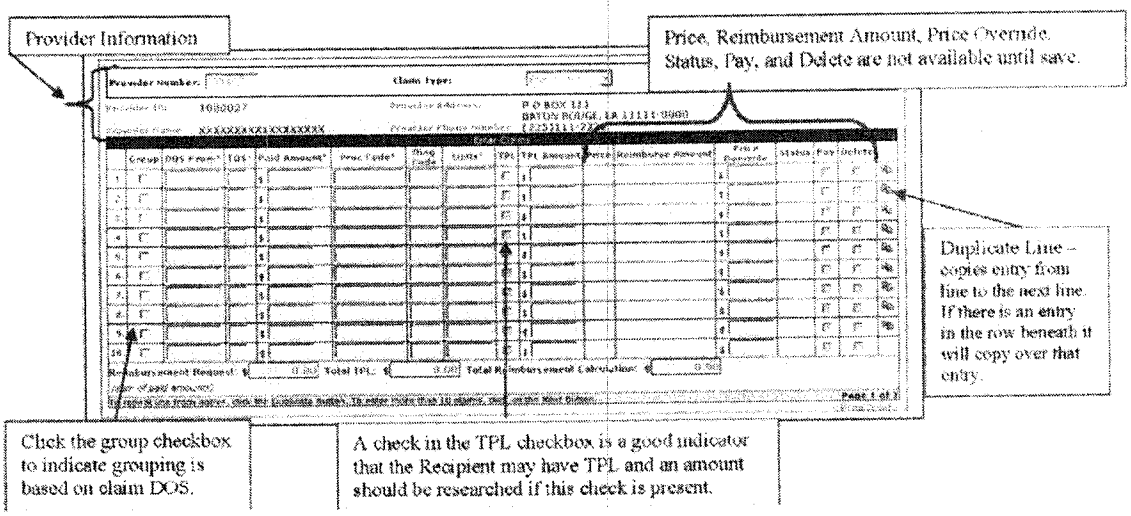
Inpatient Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

LTC Claim
Group, DOS From, DOS To, Paid Amount, Diag Code, Units

Outpatient Claim
Group, DOS From, TOS, Paid Amount, Proc Code, Diag Code, Units

Pharmacy Claim
Group, DOS From, Paid Amount, NDC Code, Diag Code, Units, Emer, Preg, Inpat, Co-Pay

Professional Claim
Group, DOS From, TOS, Paid Amount, Proc Code, Diag Code, Units

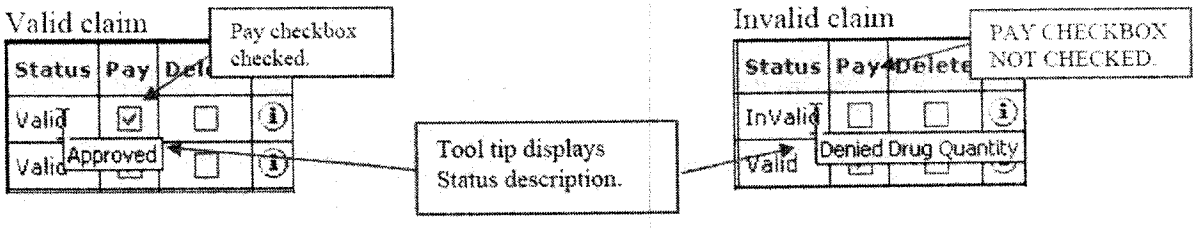


Notes:

- *Price Override, Pay, and Delete options are not available until some form of 'Save' has been administered.*
- *For a Pharmacy Claim, after adding a claim (only the first time it is saved) the **Pregnant** checkbox is selected if Medicaid Data indicates that the Recipient is pregnant as of DOS From. The **Pregnant** checkbox can be selected or de-selected accordingly to affect co-payment exemption. Any changes you make to the checkbox are saved.*
- *For a Pharmacy Claim, after adding a claim (only the first time it is saved) the **Inpatient** checkbox is selected if Medicaid Data indicates that the Recipient is in an Inpatient Facility as of DOS From. The **Inpatient** checkbox can be selected or de-selected accordingly to affect co-payment exemption. Any changes you make to this checkbox are saved.*
- *If Medicaid Data indicates that the Recipient has TPL-Private, TPL-Medicare, or QMB as of DOS From, the **TPL** checkbox is selected.*

5.6.1 Claim Status

After a save, the status of a claim is displayed in the **Status** column. To view the description for a claim status, scroll over with your mouse.

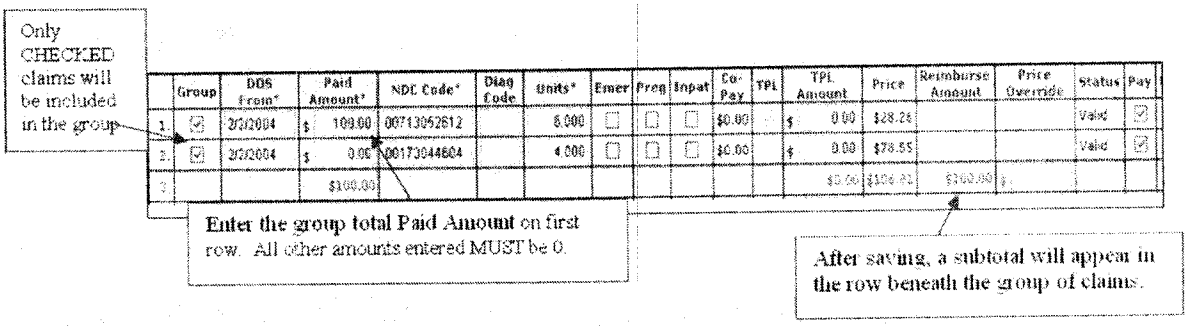


Note:

- *Review the **Pay** checkbox before completing a case. If a claim is corrected after it has been returned as invalid, the pay check box is NOT selected. The user must select the **Pay** checkbox for all paid claims.*

5.7 Grouped Claims

Claims that have the same service date can be grouped together for one single paid amount.



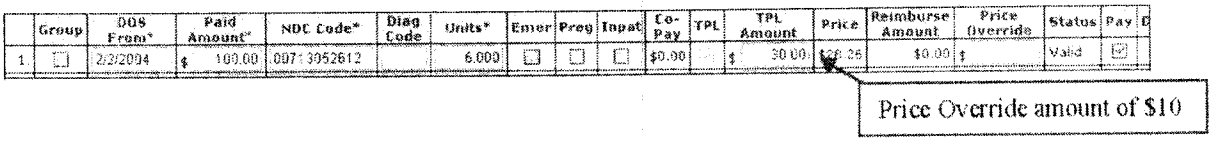
Notes:

- *The grouped claims must have the same date of service and notice that Paid Amount is a required field therefore an amount of $0 must be entered before it will be saved.*
- *The grouping will subtract any TPL applied to paid claims and apply any Price Overrides to the Group Reimburse Amount.*

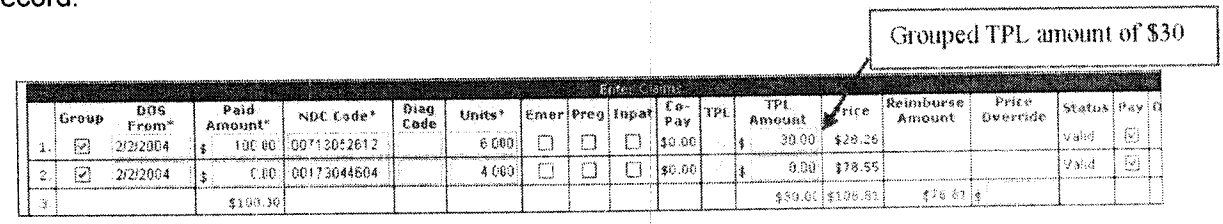
5.8 TPL Amount Override

In the **TPL Amount** textbox, enter the TPL amount that a third party is liable for (amount entered in Paid Amount textbox). Click the **Save** button.

For individual claims:
If the user enters a TPL amount, the specified value is subtracted from the calculated price.



For grouped claims:
For records with the same DOS where the **Group** checkbox is selected, those TPL Amount values with the **Pay** checkbox selected are subtracted from the total Reimburse Amount for the specified record.

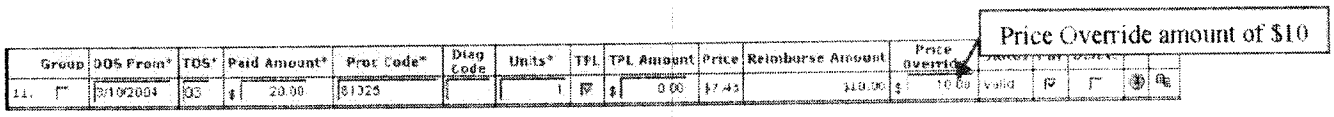


Note:

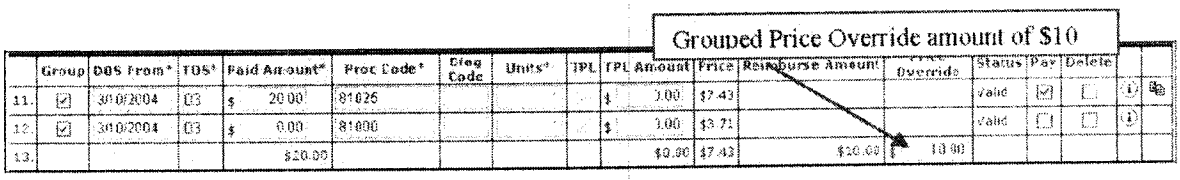
- *If the **TPL** checkbox is selected, then the Recipient may have TPL and an amount should be researched.*

5.9 Price Override

For individual claims:
Any individual price may be overridden by entering a price in the **Price Override** textbox.



For grouped claims:
To override a group of claims, enter an amount in the **Price Override** textbox on the sum line.



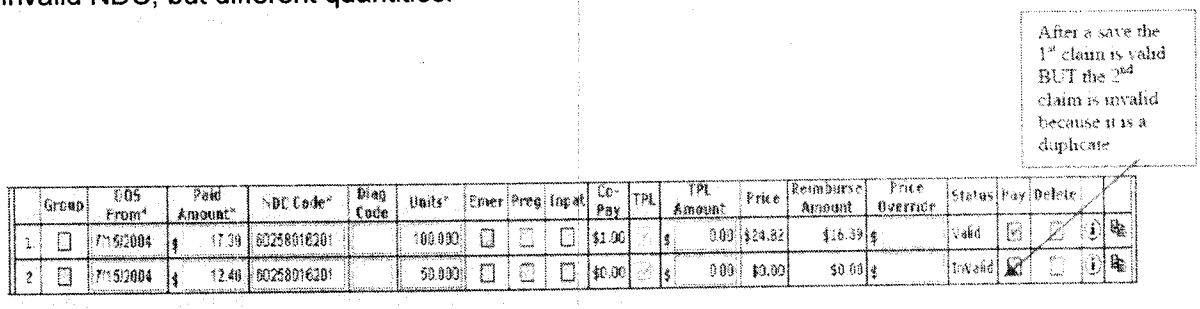
If price calculation is returned as 0:

- Edit the claim and save if the invalid reason is due to an entry error or,
  - Click the **Pay** checkbox and enter an amount in the **Price Override** textbox.
  - The user is required to enter a reason in the comments for the claim.

The system is designed to catch all duplicate claims. Therefore, any duplicate claim that has a price override amount entered will cause the original non-duplicate claim to also become a duplicate.

Example: Entering a duplicate claim:

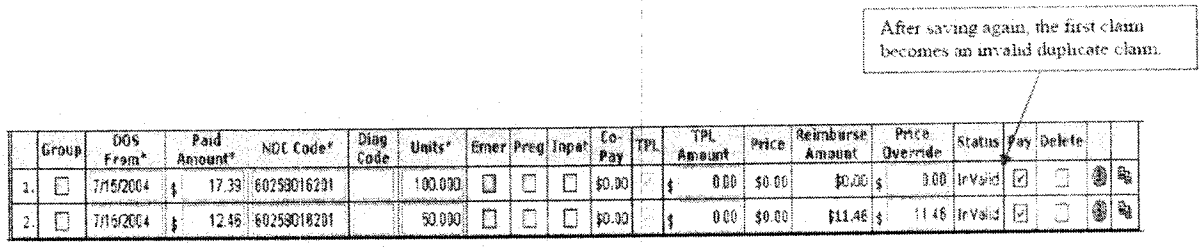
- User has two pharmacy claims entered into the system with the same DOS, same claim is invalid NDC, but different quantities.



	Group	DOS From*	Paid Amount*	NDC Code*	Diag Code	Units*	Emer	Preg	Inpat	Co-Pay	TPL	TPL Amount	Price	Reimburse Amount	Price Override	Status	Pay	Delete	
1.	☐	7/15/2004	$ 17.39	60258016201		100.000	☐	☐	☐	$1.00	☑	$ 0.00	$24.82	$16.39	$	Valid	☑	☐	
2	☐	7/15/2004	$ 12.46	60258016201		50.000	☐	☐	☐	$0.00	☑	$ 0.00	$0.00	$0.00	$	Invalid	☒	☐	

Problem: If price override is due to a duplicate claim:

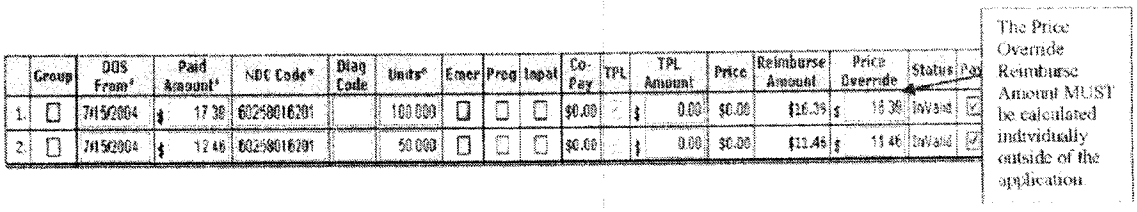
- Enter a price override for the second invalid duplicate claim. *(Because a duplicate claim is already being paid)*
- Select the **Pay** checkbox.



	Group	DOS From*	Paid Amount*	NDC Code*	Diag Code	Units*	Emer	Preg	Inpat	Co-Pay	TPL	TPL Amount	Price	Reimburse Amount	Price Override	Status	Pay	Delete		
1.	☐	7/15/2004	$ 17.39	60258016201		100.000	☐	☐	☐	$0.00	☑	$ 0.00	$0.00	$0.00	$ 0.00	Invalid	☑	☐		
2.	☐	7/15/2004	$ 12.46	60258016201		50.000	☐	☐	☐	$0.00	☑	$ 0.00	$0.00	$11.46	$ 11.46	Invalid	☑	☐		

Solution: Create a price override for both claims:

- User must enter a price override for both claims that are involved in the duplicate.



	Group	DOS From*	Paid Amount*	NDC Code*	Diag Code	Units*	Emer	Preg	Inpat	Co-Pay	TPL	TPL Amount	Price	Reimburse Amount	Price Override	Status	Pay
1.	☐	7/15/2004	$ 17.39	60258016201		100.000	☐	☐	☐	$0.00	☑	$ 0.00	$0.00	$16.39	$ 16.39	Invalid	☑
2.	☐	7/15/2004	$ 12.46	60258016201		50.000	☐	☐	☐	$0.00	☑	$ 0.00	$0.00	$11.46	$ 11.46	Invalid	☑

Notes:

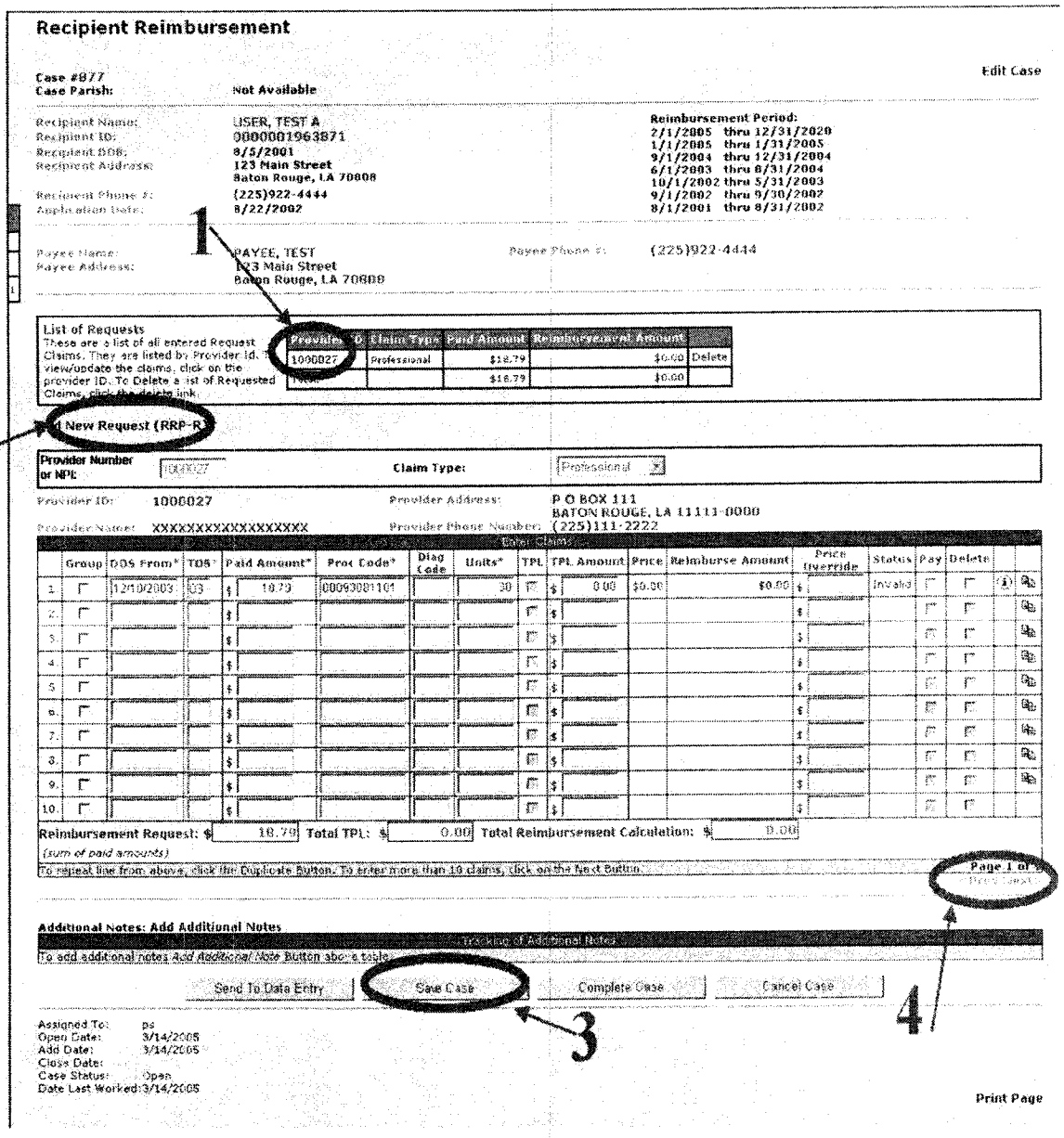
- *For a price override the **Pay** checkbox must be selected in order for the amount to be applied.*
- *Any calculations for a duplicate claim that has a price override must be done by hand. The application is not designed to calculate a reimbursement amount for duplicate claims.*

5.10 Save Case

After all claims for a given case have been entered, a case must be saved before the claims will be priced. A save returns a Price, a Reimburse Amount, and a Status, along with an icon to enter comments.

After a save, each claim is checked for validity and an indicator for TPL is displayed on the screen for the specified claim. If all edits are met, a pricing amount is returned based on the number of units entered. If any edits fail, a price is not calculated and a status of invalid is returned along with a reason for invalidity.

There are four ways to save a case:

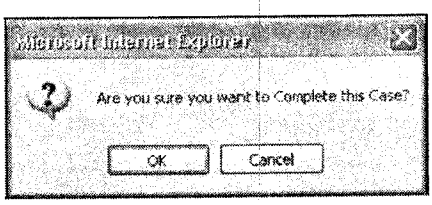


1. If a request is currently open, clicking on the **Provider ID #** link saves all information on the screen, and the selected request is displayed.
2. If a request is open, clicking on the **Add New Request** link saves all information on the screen, and the user is enabled to enter a new request.
3. If a request is currently open, clicking on the **Save Case** button saves all information on the screen and keeps the current request open.
4. Click on either the **Prev** (previous) or **Next** link to save any new claims or update any existing claims that have been saved and are currently displayed on the screen. If claim entry exceeds ten claims for one request, the **Next** link is activated.

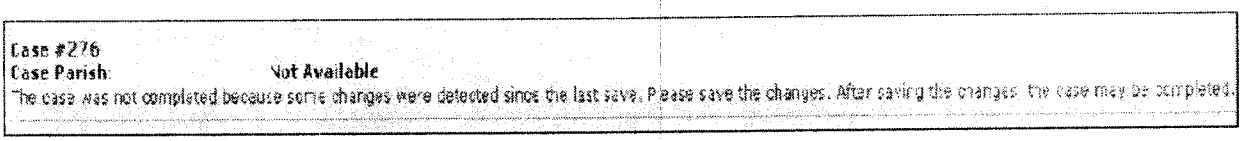
After any save method (except for **<Prev Next>**), the request is displayed along with all other requests in the **List of Requests** box.

5.11 Complete Case

A case remains in Open status until the **Complete Case** button is selected. A prompt occurs to notify the user that the case will be closed.



Attempting to Complete Case:
If you attempt to complete a case that has outstanding issues, the case is not completed and the following alert is displayed:

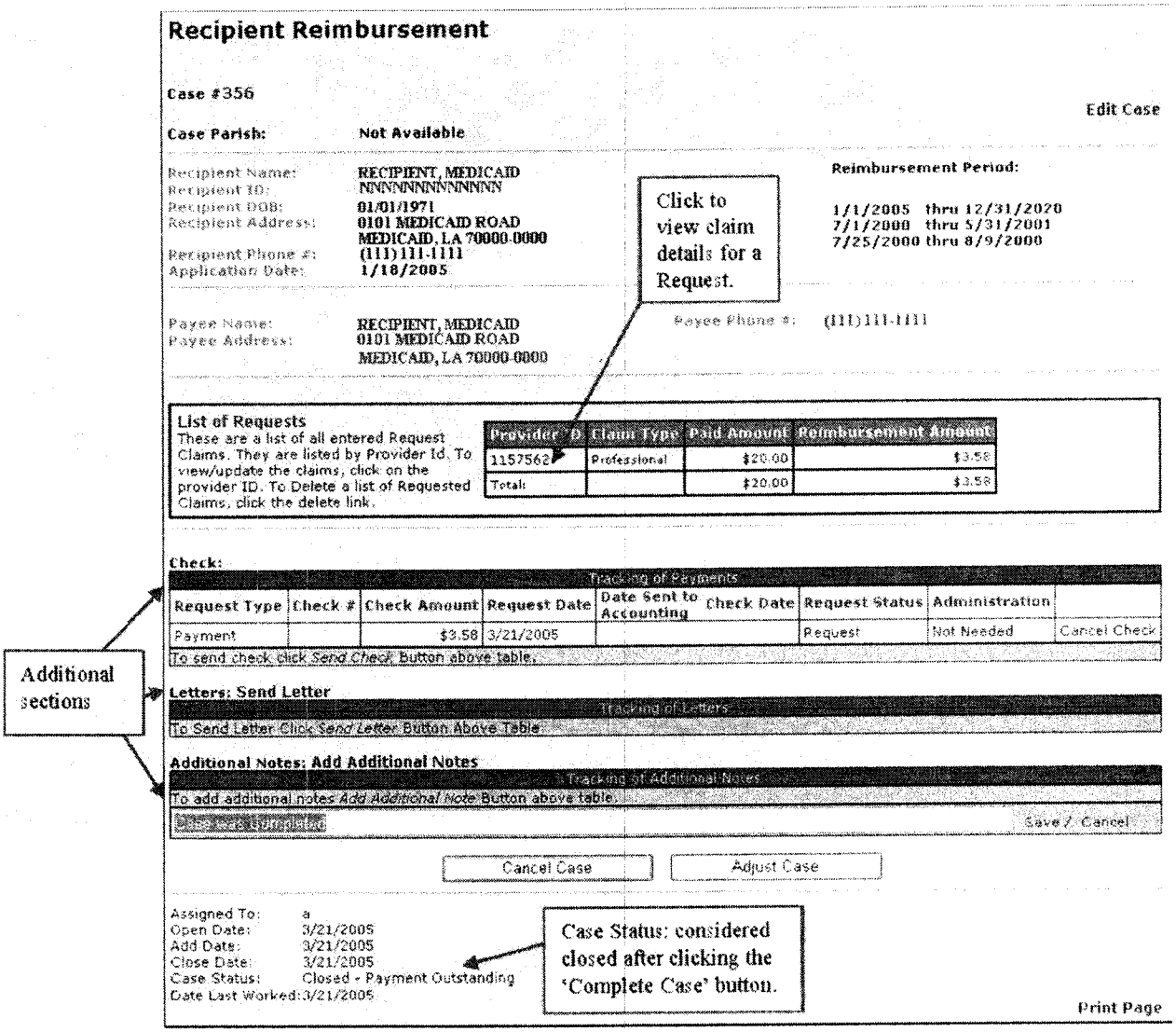


Other conditions that return an alert include:

1. No Save – Closing or completing a case without saving changes. (An alert explains that the case was not completed and you must save changes first, and then complete the case.)
2. Total Reimbursement Amount > Paid Amount – Closing a case in which the total reimbursement amount is greater than the paid amount. (An alert explains that the case was not completed because one of the request's reimbursement amounts was greater than the request's paid amount.)

After successfully closing an open case, additional sections are displayed below the **List of Requests** box:

- Checks (If the total Reimbursement Amount is > 0)
- Letters
- Add Additional Notes



Notes:

- *A case cannot be completed until displayed claims have been saved and no changes have been made.*
- *A case cannot be completed if the total payout on any request is greater than the amount paid on that request.*

Case Status:

Denied – Total 0: Case status if the reimbursement amount is 0.

- A denial letter shows in the table below the Letters section.

Closed Payment Outstanding: Case status if the reimbursement amount is greater than 0.

- A payment request is generated for the amount of all the recipient reimbursement claims that are selected in the grid.

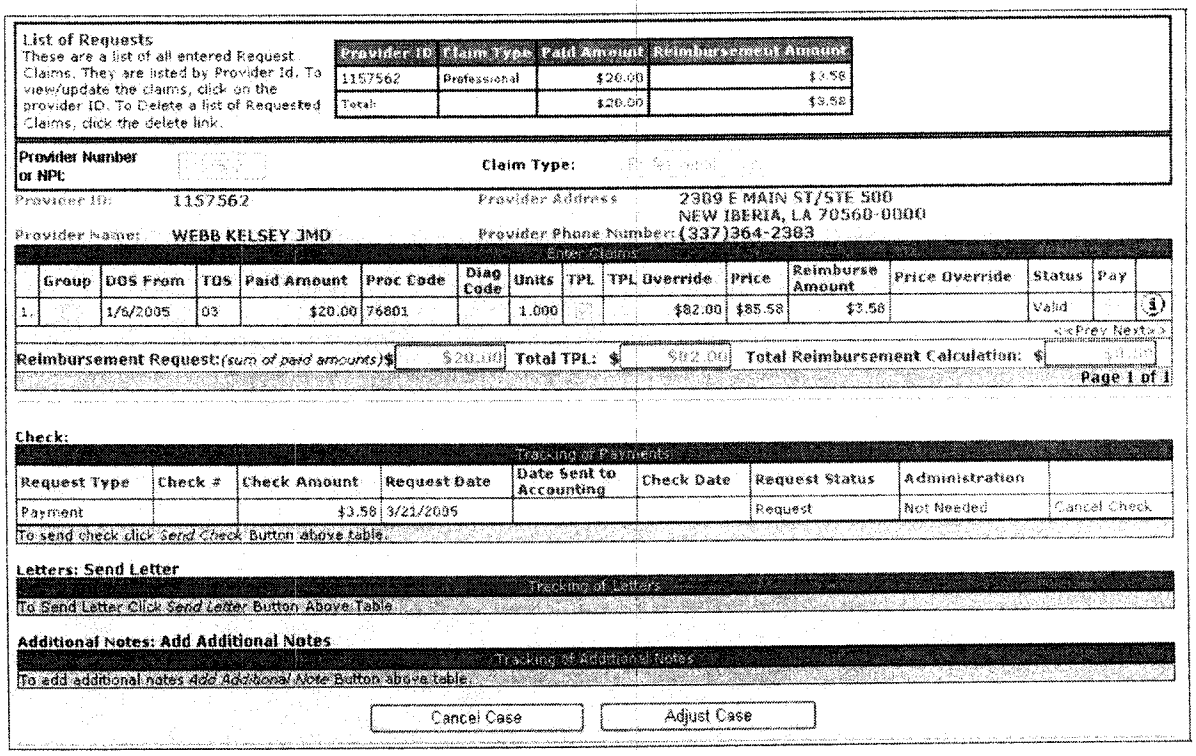
- The case is closed.
- The check shows in a table below the Checks Section of the detail page.
  If the check requires administrative approval because 1) it's over the average check amount, 2) it is the second check written on a case, or 3) one of the claims has a price override, the check will be held until it receives administrative approval. If approval is given, the case remains in Closed Payment Outstanding Status. If approval is denied, the case will be in Open status.
- When a check is sent, a letter shows in the table below the Letters section.

Closed Paid - Check has been reconciled by accounting. This will probably take 1-2 months.

Cancelled – Removes all claims from the application and MMIS duplicate checking as if claims were never filed. If a cancelled case has outstanding requested checks, they will also be cancelled. If you try to cancel a case that has outstanding sent checks, the application will not be able to cancel the case until the checks are marked as voided.

5.12 Closed Case Detail Screen

After a case is closed, click on a Provider ID in the List of Requests to view the claim details. All claims for the specified request are displayed in a non-editable format.



5.13 Checks

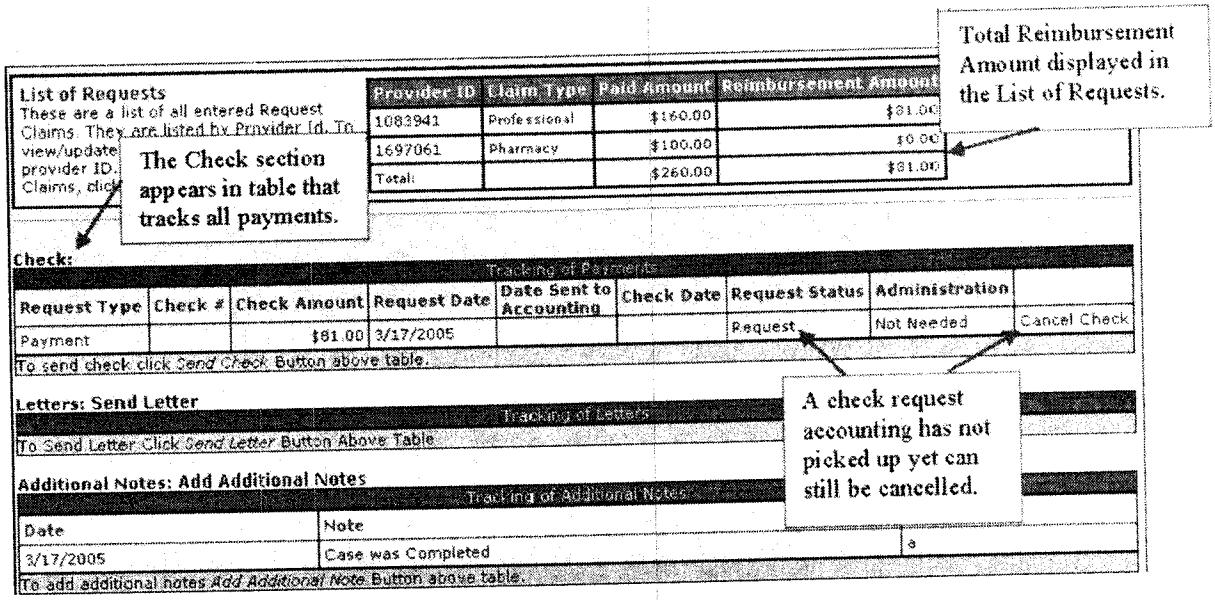
The first check request is generated automatically after completing a case. The Request Type (*Payment or Void*) is displayed along with the Request Status.

Request Status

- Requested – not in the Accounting system yet.
- Pending – in the Accounting system
- Sent – received an update from the Accounting system w/ date cut and check number for payment, or an acknowledgement for a void
- Clear – received an update from Accounting w/ date check cleared
- Void – received an update from Accounting that the check has been voided, voids will not have this status
- Cancelled – checks/voids receive this status if the check is cancelled when in request mode

5.13.1 Request Status - Request (Check)

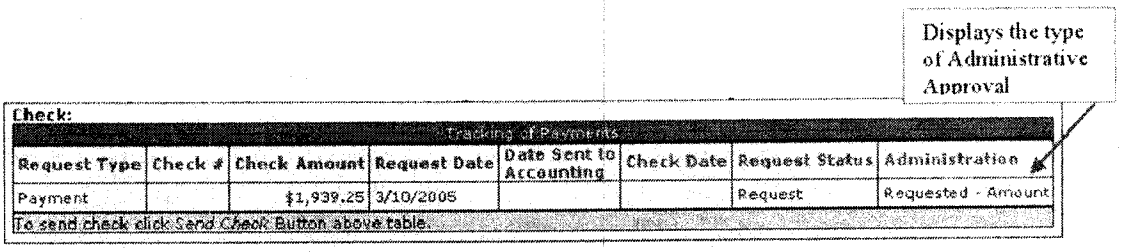
A check generates only if the entire case Total Reimbursement Amount is greater than $0.



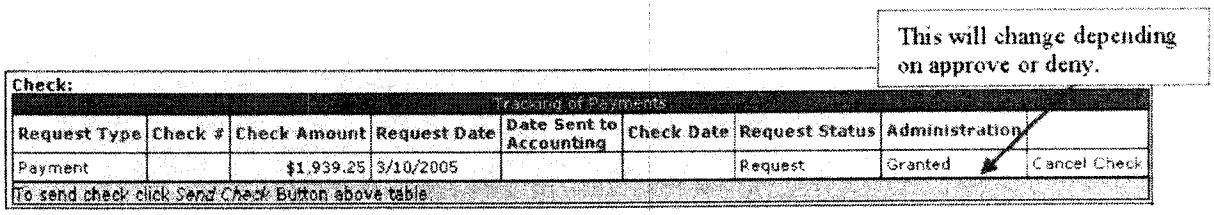
5.13.2 Request – Administration Approval

If payment requires administrative approval, the check is held until it receives the approval. The three types of Administrative approval are:

1. Requested – Amount: If a payment request exceeds the normal amount.
2. Requested – Reissued: If it is the second check written on a case.
3. Requested – Price Override: If any claim for a case has a price override.

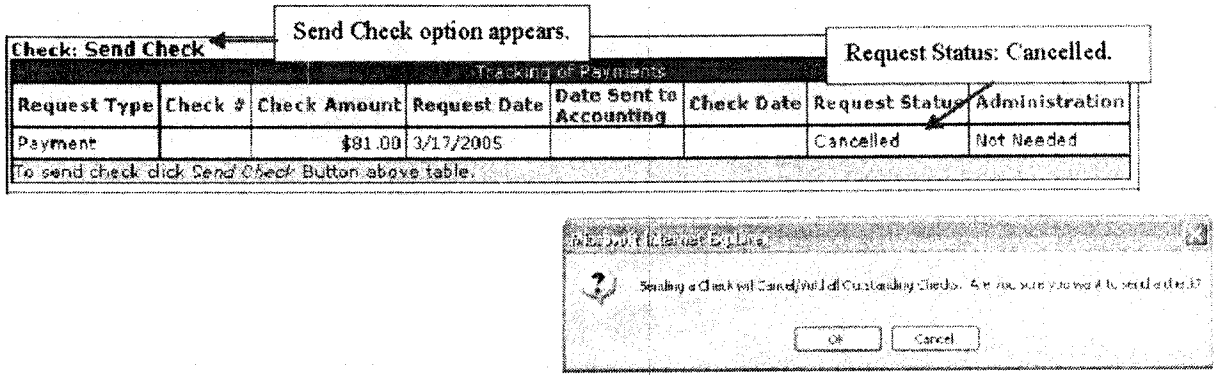


Administration:
Approved – the case remains in Closed Payment Outstanding Status.
Denied – the case is in Open status.



5.13.3 Request Status – Cancelled (Check Request)

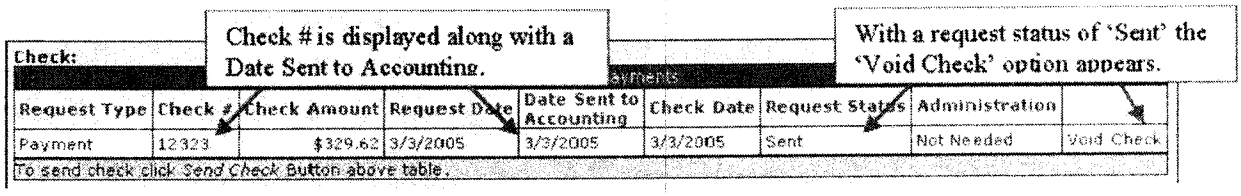
A check request can be cancelled only before Accounting has picked up the check.



To generate a new check request, click the **Send Check** link; a confirmation window is opened; click the **OK** button to send the check.

5.13.4 Request Status - Sent

If Accounting has already picked up the check and it has been cut, the check cannot be cancelled. Instead, the check must be voided.



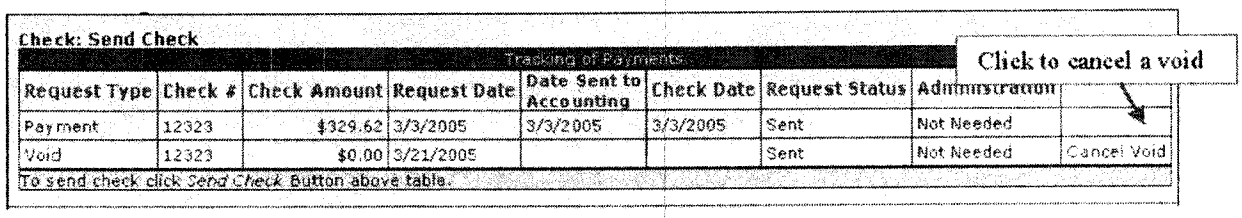
Check:

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration	
Payment	12323	$329.62	3/3/2005	3/3/2005	3/3/2005	Sent	Not Needed	Void Check

To send check click *Send Check* Button above table.

After a sent check has been voided, the Request Type is 'Void' and the Check Amount, Date Sent to Accounting, and Check Date fields are all cleared.



Check: Send Check

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration	
Payment	12323	$329.62	3/3/2005	3/3/2005	3/3/2005	Sent	Not Needed	
Void	12323	$0.00	3/21/2005			Sent	Not Needed	Cancel Void

To send check click *Send Check* Button above table.

In the event that the void was a mistake, click **Cancel Void** and the Void request will be cancelled.

Check:

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration	
Payment	12323	$329.62	3/3/2005	3/3/2005	3/3/2005	Sent	Not Needed	Void Check
Void	12323	$0.00	3/21/2005			Cancelled	Not Needed	

To send check click *Send Check* Button above table.

5.13.5 Request Status – Void

If a check has been voided, another check can be requested for the case by clicking the **Send Check** button. When a check void has been confirmed through bank reconciliation, both the check and void request have status set to 'Void'.

Check: Send Check

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration
Payment	555	$101.05	3/3/2005	3/3/2005	3/3/2005	Void	Not Needed
Void	555	$0.00	3/11/2005			Void	Not Needed

To send check click *Send Check* Button above table.

5.13.6 Request Status – Pending

If a check is pending, it cannot be cancelled or voided, and the **Send Check** option is not available.

Check:

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration
Payment		$224.95	3/11/2005	3/22/2005		Pending	Not Needed

To send check click *Send Check* Button above table.

5.13.7 Request Status – Clear

When bank reconciliation shows that a check has been cleared, the check status is set to clear. Shown below is the screen when the checks have been cleared through bank reconciliation. A new check cannot be requested, and the check cannot be voided or cancelled if a check has been cleared.

Check:

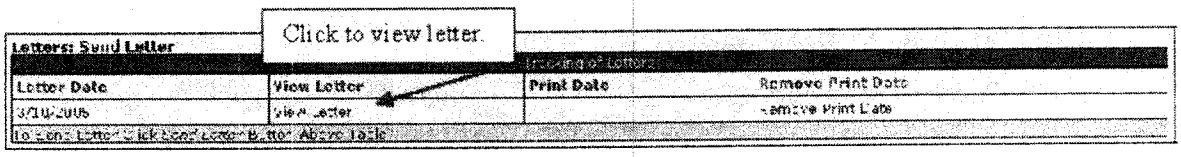
Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration
Payment	123456	$224.95	3/11/2005	3/2/2005	3/22/2005	Cleared	Not Needed

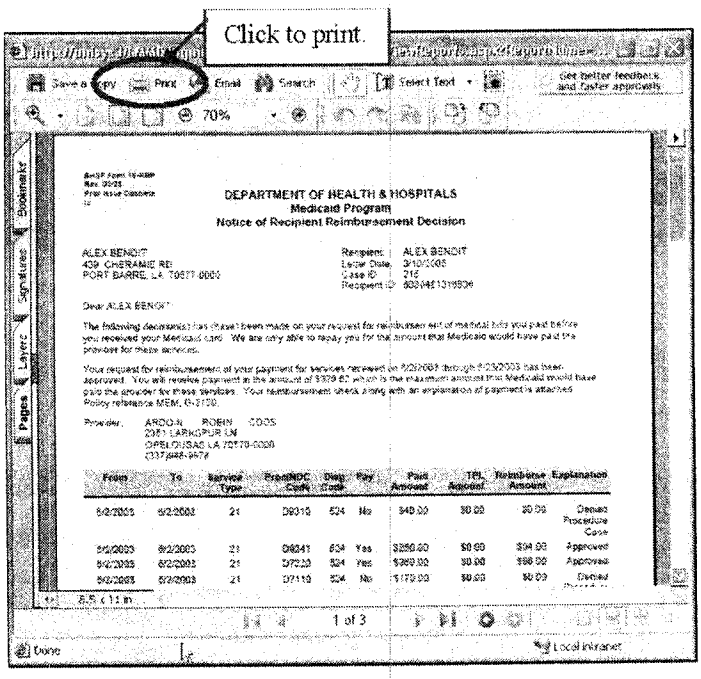
To send check click *Send Check* Button above table.

5.14 Letters

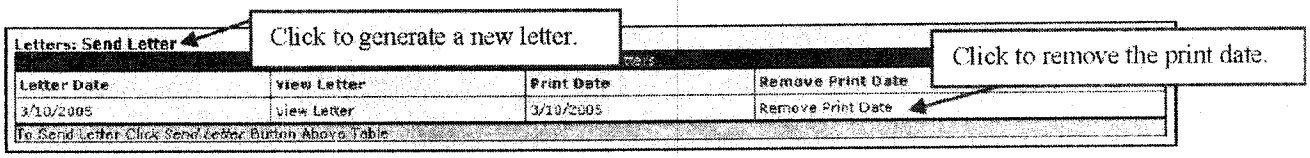
A list of dated letters regarding a case is displayed in the letters section. This section is available only after a case has been closed. A user can generate new letters at any time by clicking the **Send Letter** link or view existing letters by clicking the **View Letter** link.



The letter will open in PDF format to view or print.

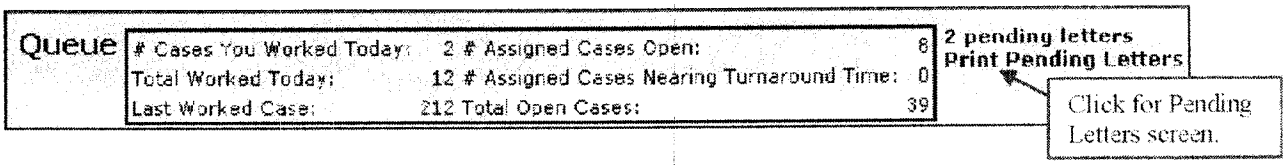


If the letter was not printed, the option to remove the print date is available by clicking the **Remove Print Date** link.

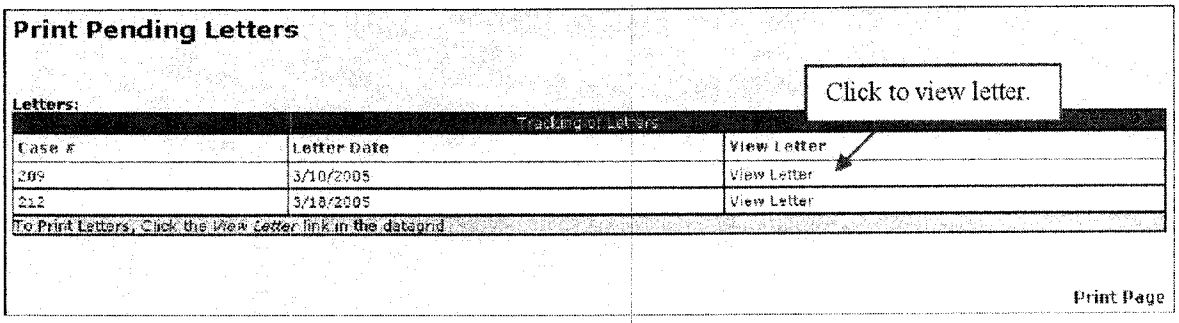


5.15 Print Pending Letters

To access the Pending letters queue list, navigate to the Queue screen and click on the **Print Pending Letters** link.

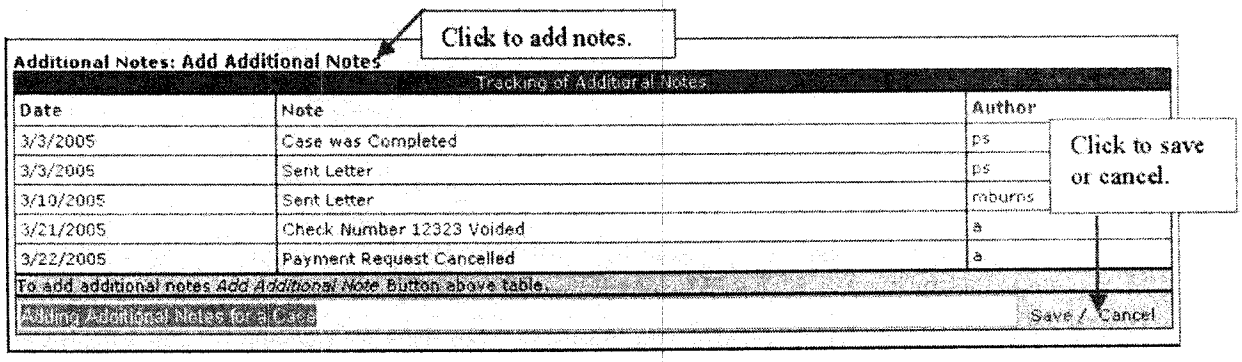


The Print Pending Letters screen is displayed. This screen displays a list of all letters that have not been printed for checks that have been cut. This allows users to print those letters without having to open the entire case. The print date is stored in the database.



5.16 Add Additional Notes

A list of dated notes regarding a case is displayed in the Additional Notes section of a case. Users may add new notes into the section by clicking the **Add Additional Notes** link.



Certain actions performed on a case will cause the Additional Notes section to open for entering case tracking information.
Prefabricated entries are written that correspond to the type of action being performed.

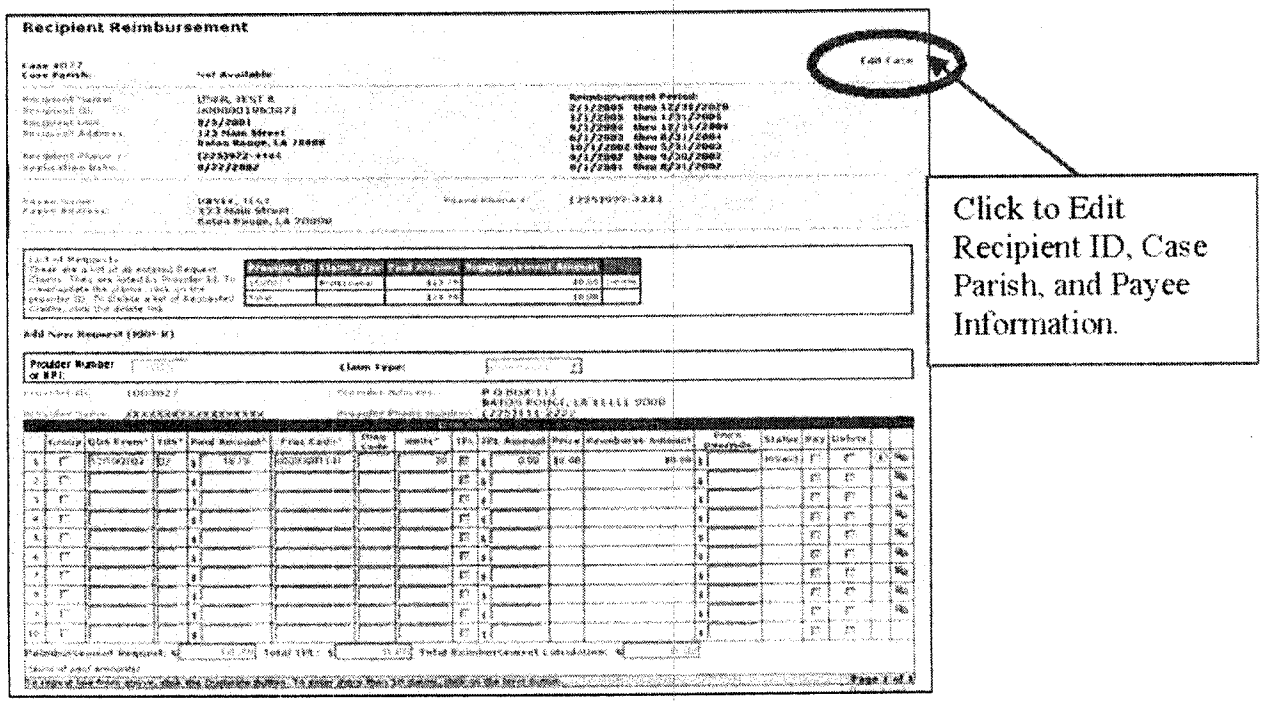
These notes are not required and therefore an option to cancel or save is at the end of the line. The preexisting note can have additional notes added to it or removed completely to allow a user to enter what they want.

Note:

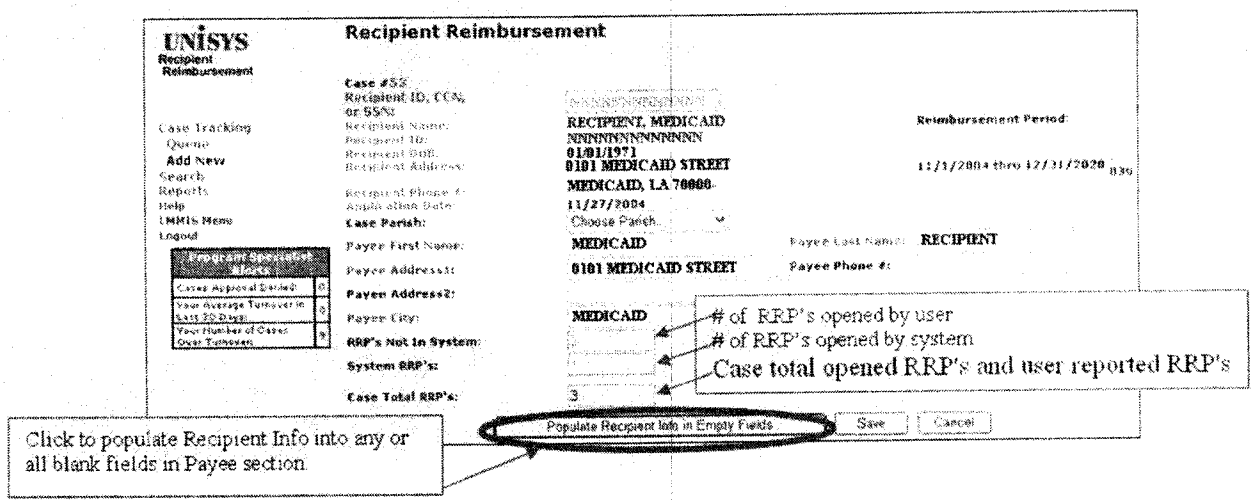
- *It is very important to save all notes and remember to enter notes any time a case is modified*
- *Upon saving a note, the entry date is saved and displayed along with the name of the user.*

5.17 Case Edit Screen

After a case has been added, pressing the **Edit Case** button allows a user to make changes to selected case information. Recipient ID, Case Parish, and Payee Information are the only modifiable information. If a claim has been added to the case, the Recipient cannot be changed.



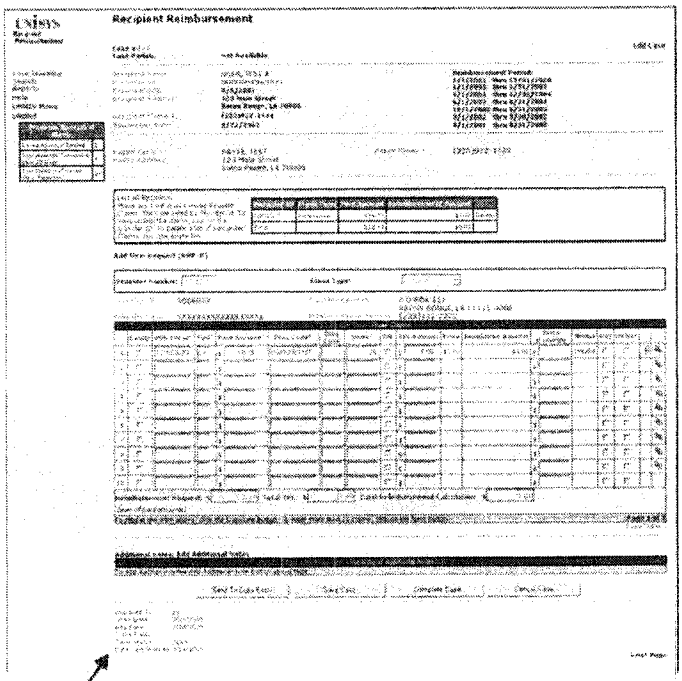
The only editable fields on this screen are Case Parish and all of the Payee information. The Recipient ID, CCN, and SSN are displayed but not editable.



If the recipient and payee have similar information, type in the Payee information that differs from the Recipient information and click the **Populate Recipient Info** button. If the recipient has had previous cases, all previous payees are displayed in a dropdown.

5.18 Footer

Information for each case is displayed in the footer at the bottom of the screen.



Footer Information

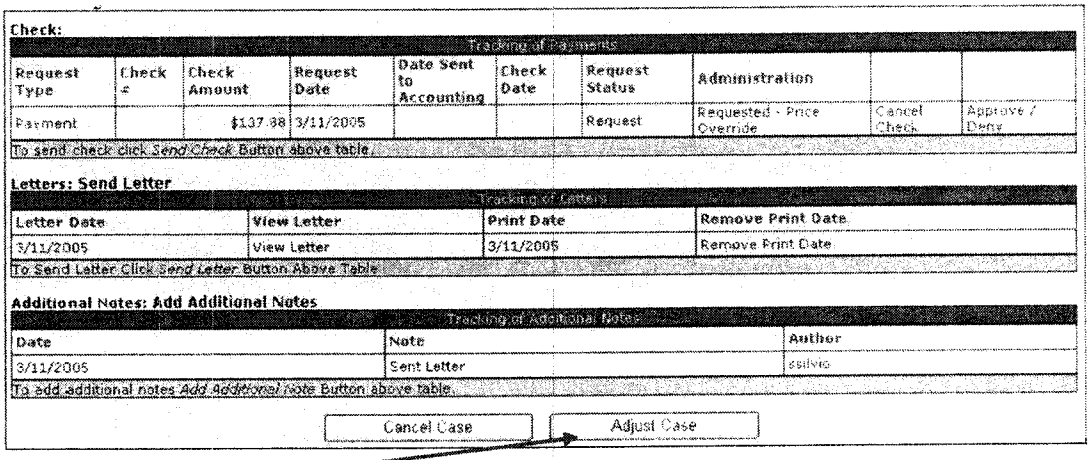
Last Assigned:	
Assigned To:	RRAdmin - Admin, RR
Received Date:	4/12/2006 12:00:00 AM
Open Date:	4/12/2006 8:30:00 AM
Add Date:	4/12/2006 8:29:57 AM
Close Date:	6/13/2006 12:27:00 PM
Case Status:	Adjust
Date Last Worked:	6/13/2006 12:35:28 PM
Date First Worked:	4/12/2006 8:29:57 AM

- **Last Assigned:** -- The Specialist previously assigned to the case. Populated only if the case has been reassigned at least once.
- **Assigned To:** – Program Specialist who originated the case, or in case of re-assignment, the current person assigned to the case.
- **Received Date:** -- Entered by the case worker upon adding the case. This is the date the case worker received the case, not the date it was entered into the system.
- **Open Date:** – The date the case was first worked by the assigned Program Specialist
- **Add Date:** – Date the case was entered into the system
- **Close Date:** – Date the case was closed
- **Case Status:** – Current status of case
- **Date Last Worked:** – The last date that the case was worked.
- **Date First Worked:** -- The date set once an action is taken on the case.

5.19 Adjust Case

After a case has been closed, entire requests and individual claims can be removed from the case so that they are removed from the application and MMIS duplicate checking as if they were never filed.

Open a closed case detail page.



Check:

Tracking of Payments

Request Type	Check #	Check Amount	Request Date	Date Sent to Accounting	Check Date	Request Status	Administration		
Payment		$137.88	3/11/2005			Request	Requested - Price Override	Cancel Check	Approve / Deny

To send check click *Send Check* Button above table.

Letters: Send Letter

Tracking of Letters

Letter Date	View Letter	Print Date	Remove Print Date
3/11/2005	View Letter	3/11/2005	Remove Print Date

To Send Letter Click *Send Letter* Button Above Table

Additional Notes: Add Additional Notes

Tracking of Additional Notes

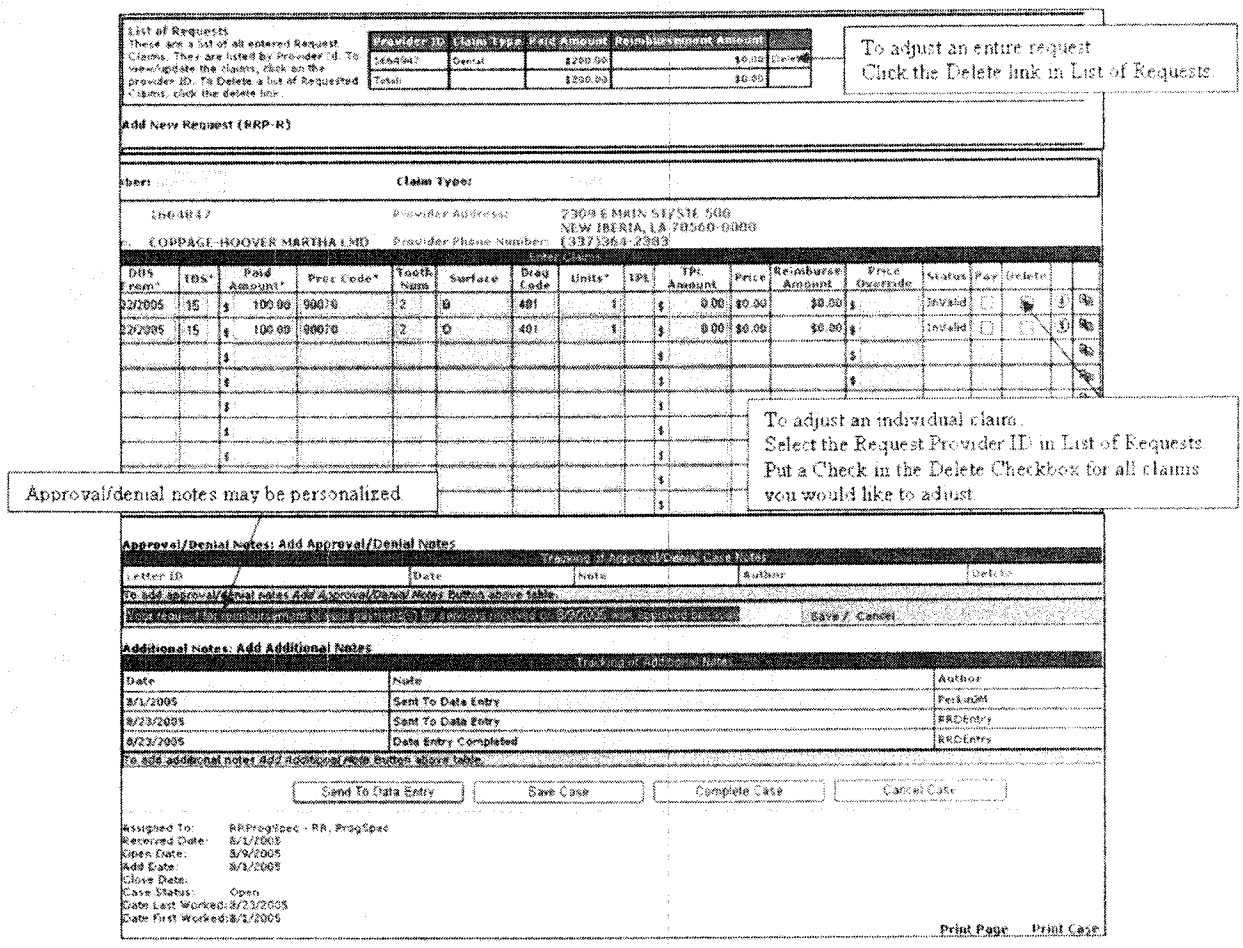
Date	Note	Author
3/11/2005	Sent Letter	ssilvio

To add additional notes *Add Additional Note* Button above table.

Cancel Case | Adjust Case

Click on the **Adjust Case** button at the bottom of the Closed Case

The case will open in adjust mode to allow deletions. Case status is changed to 'Adjust'.



Notes:

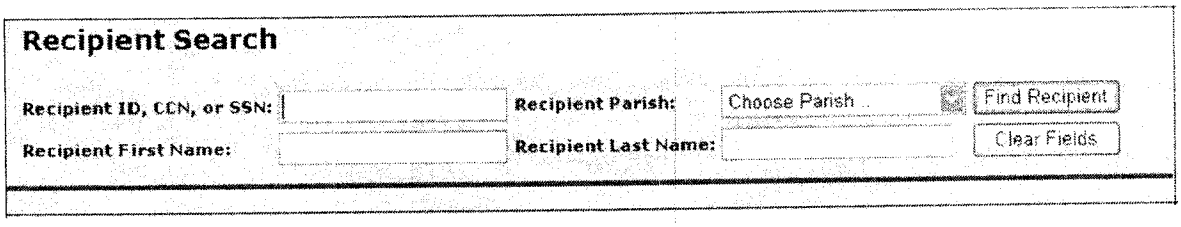
- *Once a case has been completed, additional claims or requests CANNOT be added.*
- *If a case is in adjust mode, the only action that can take place is delete.*

6.0 Search Screens

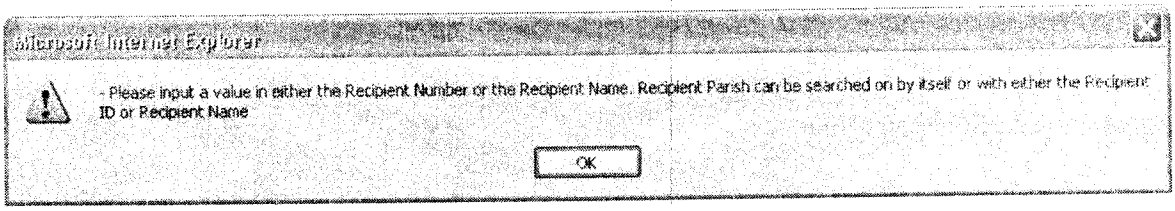
All search screens open in a new window. The search window remains open to enable you to use the search screens while working on a case in the main screen. However, anytime you click on a **Case #** link, the current window closes and the case opens on the main screen.

6.1 Recipient Search

From the Navigation menu, expand **Search** and click on the dropdown **Recipient**.



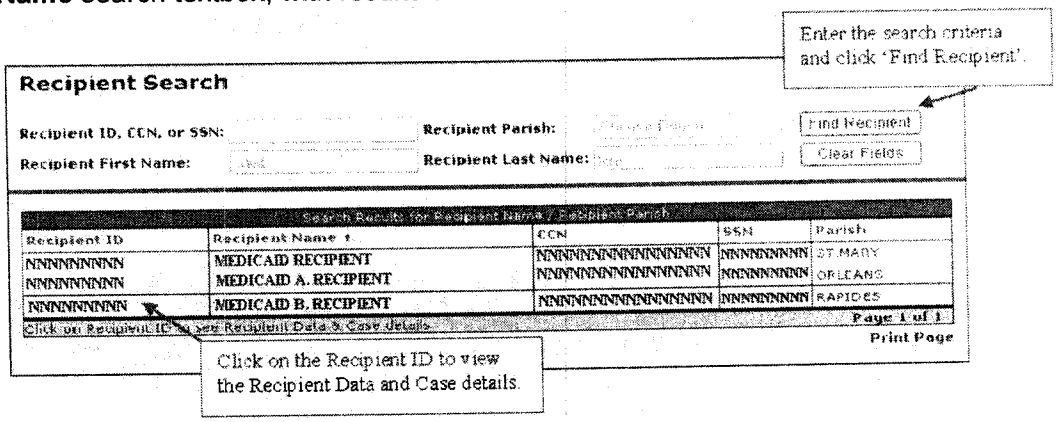
A Recipient Number, Name, or Parish is required to perform a search. If a user attempts to perform a search without at least one of these fields, a validation message will occur.



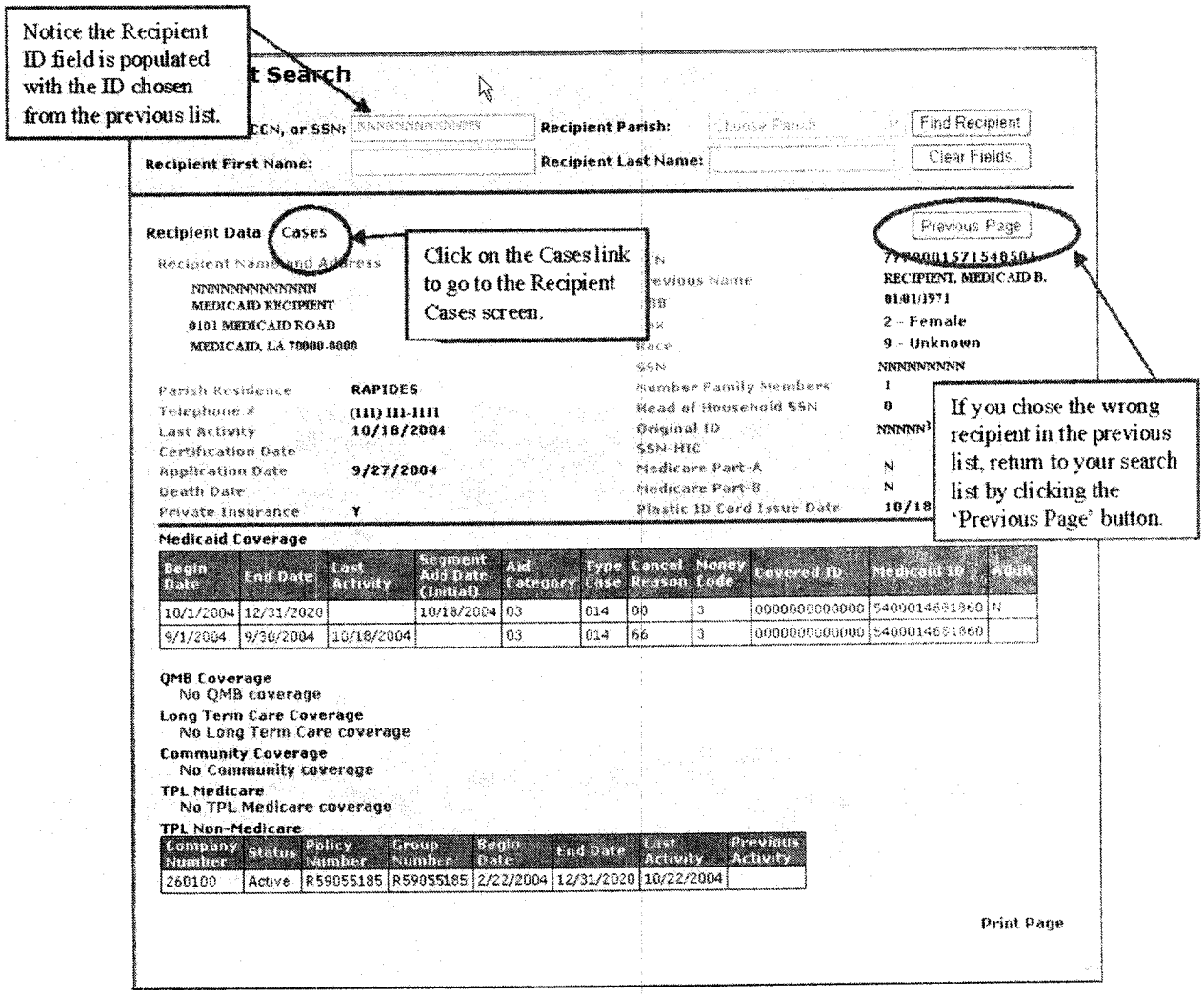
Recipient Name Search

- Perform a search based on either a Recipient First Name or a Recipient Last Name, or a combination of the two.
  - The Recipient List Screen will display all search results that meet the criteria.
  - If you don't know the recipient's entire name you can perform a search based on the first two or three letters in the First Name and/or Last Name fields.

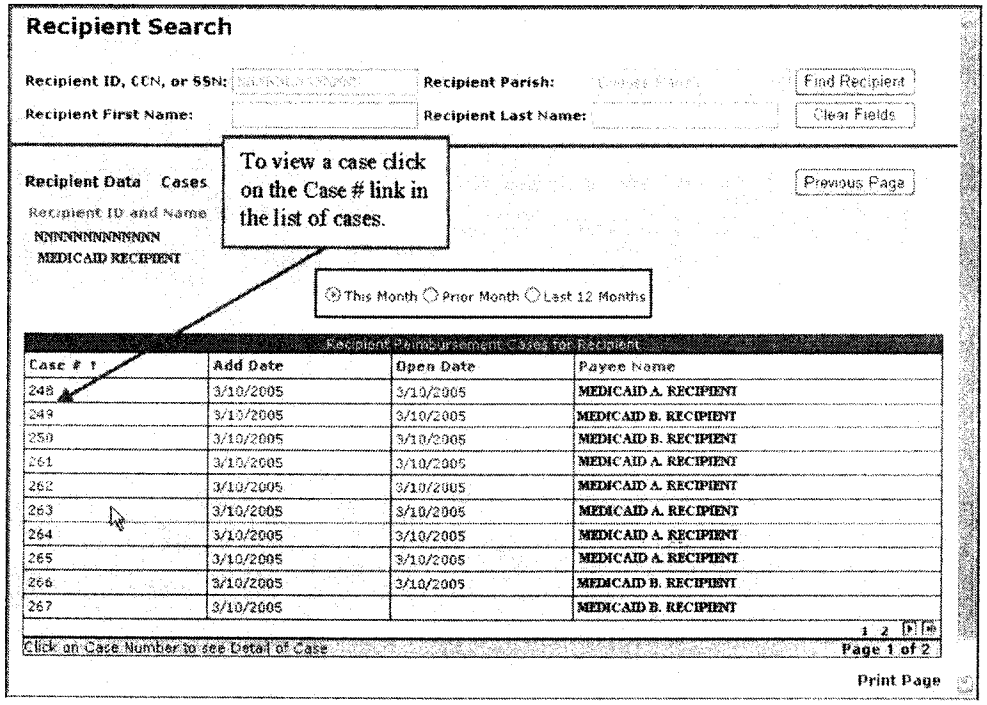
For example, if you are looking for a case that involves a recipient named Medicaid B. Recipient, you may enter "Med" in the **First Name** search textbox and "Rec" in the **Last Name** search textbox, with results similar to those shown below:



- The Recipient Data Screen opens to view all recipient information and verify Reimbursement Periods along with the Type of Case for each period.
    - If you chose the wrong recipient from the list, you can return to your search list by clicking the **Previous Page** button.



- The Recipient Cases Screen displays a list of all cases for the specified recipient.



Recipient ID, CCN, or SSN Search:

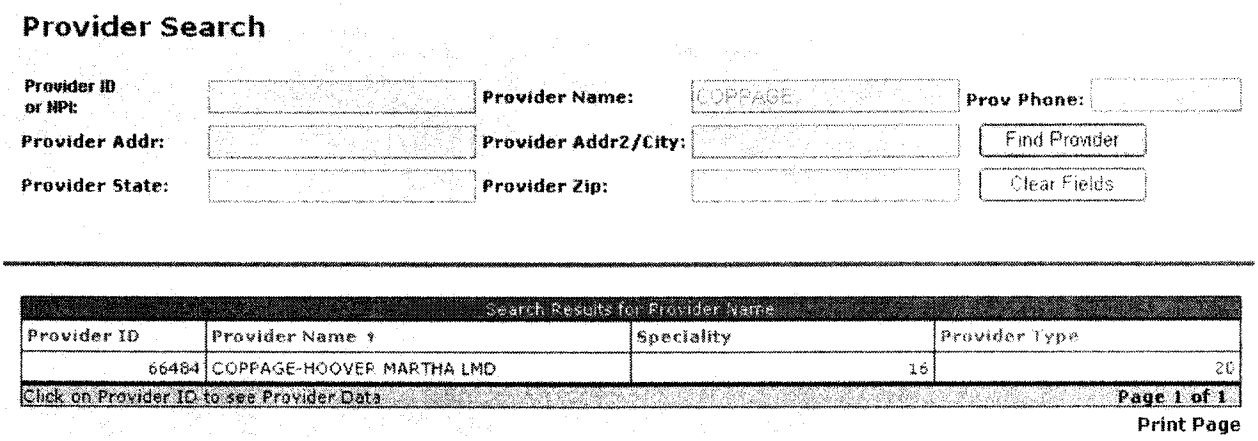
- If you already know the Recipient's ID, a search can be done based on Recipient ID, CCN, or SSN. Enter the exact Recipient ID, CCN, or SSN and click the **Find Recipient** button.
  - You will be taken directly to the Recipient Data Screen to view all recipient information and verify Reimbursement Periods along with the Type of Case for each period.

Notes:

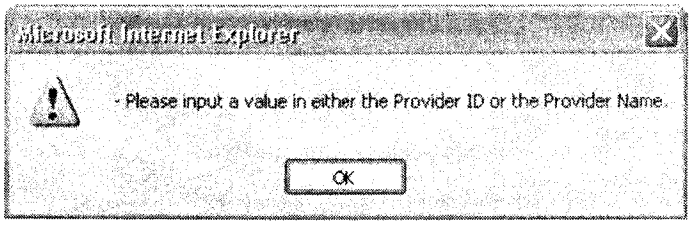
- *After performing a search, the fields are disabled and you must click the **Clear Fields** button to perform a new search.*
- *If you click on the **Case #** link on the Cases Screen, the search screen closes and the specified detail opens on the application main screen.*

6.2 Provider Search

From the Navigation menu, expand **Search** and click on the dropdown **Provider**.



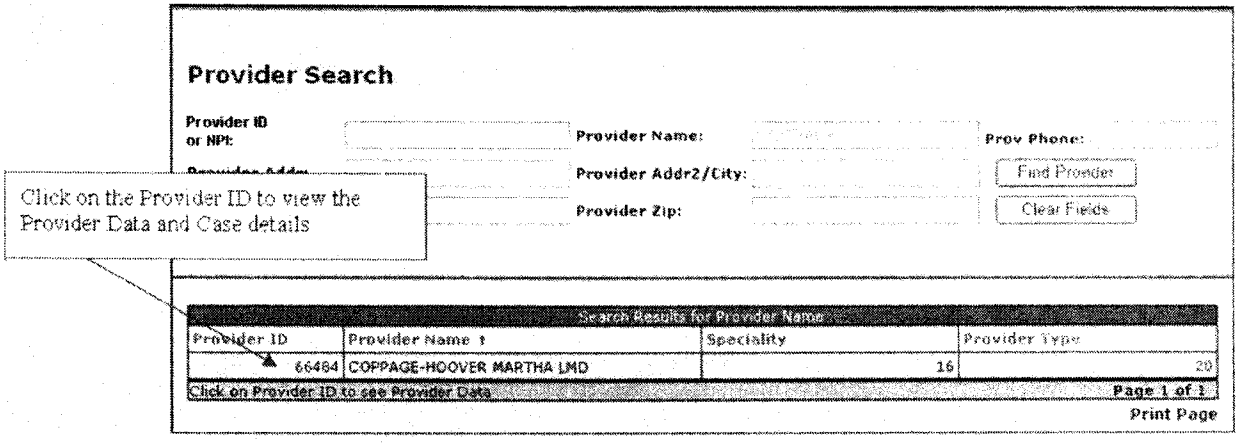
A Provider Number or Name is required to perform a search. If a user attempts to perform a search without at least one of these fields, the following reminder is provided:



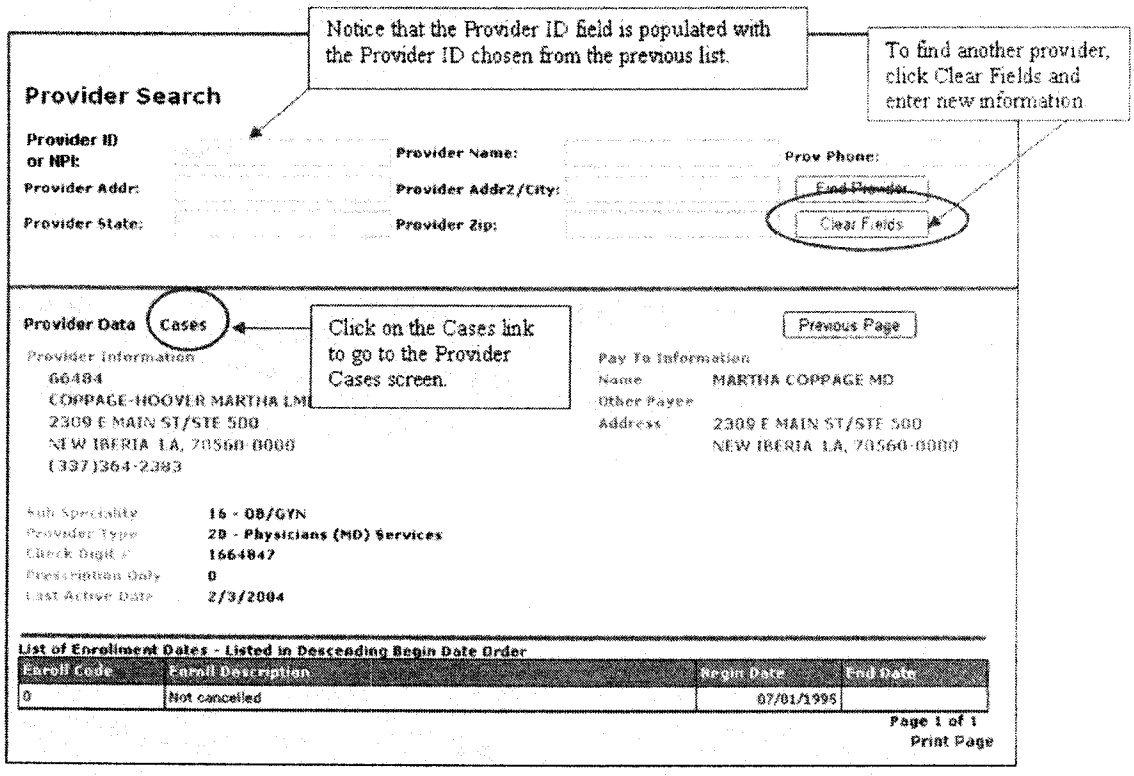
Provider Name Search

- To perform a search based on a Provider Name, enter your Provider Name search criteria and click the **Find Provider** button.
  - The Provider List Screen will display all search results that meet the criteria.
  - If you don't know the exact name of the Provider, you can perform a search based on a few letters of the name.

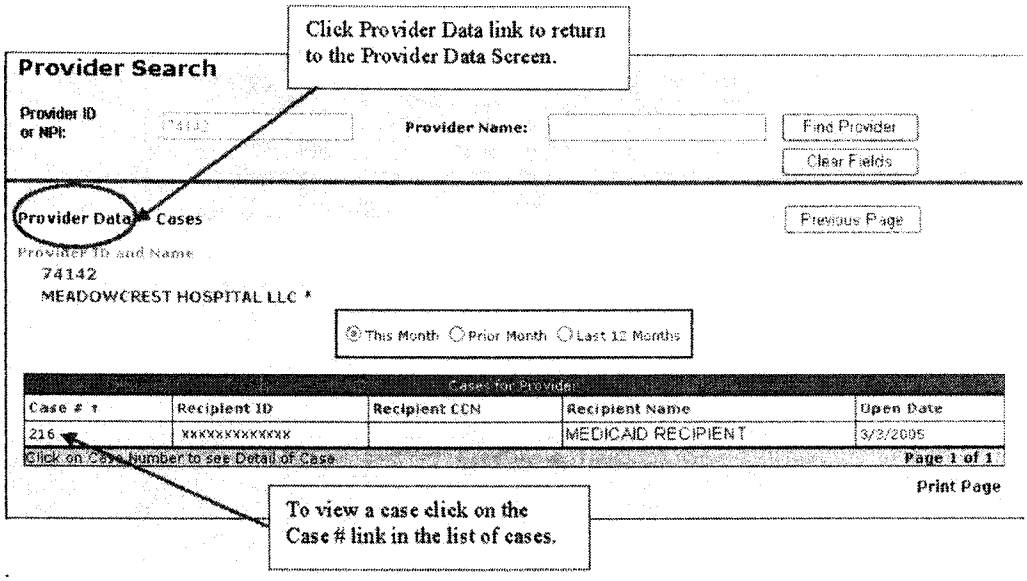
*Example: To search for Martha Coppage-Hooper, enter "Coppage" in the **Provider Name** field.*



- Click on the Provider ID to view all provider information and verify enrollment dates.



- The Provider Cases Screen displays a list of all cases for the specified recipient.



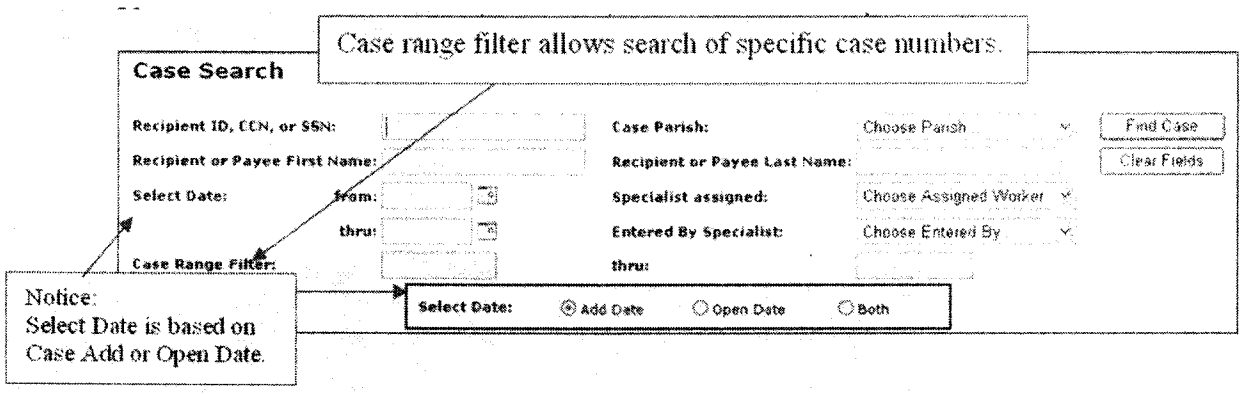
- If you already know the Provider ID, a search can be based on Provider Number or Provider Check Digit Number. Enter the exact Provider Number or Provider Check Digit Number (74142 or 1741426) and click on the **Find Provider** button.
    - The Recipient Data Screen displays all recipient information and verifies Reimbursement Periods along with the Type of Case for each period.

Notes:

- *After performing a search, the fields are disabled and you must click the **Clear Fields** button to perform a new search.*
- *If you click on the **Case #** link on the Cases Screen, the search screen closes and the specified detail opens on the application main screen.*

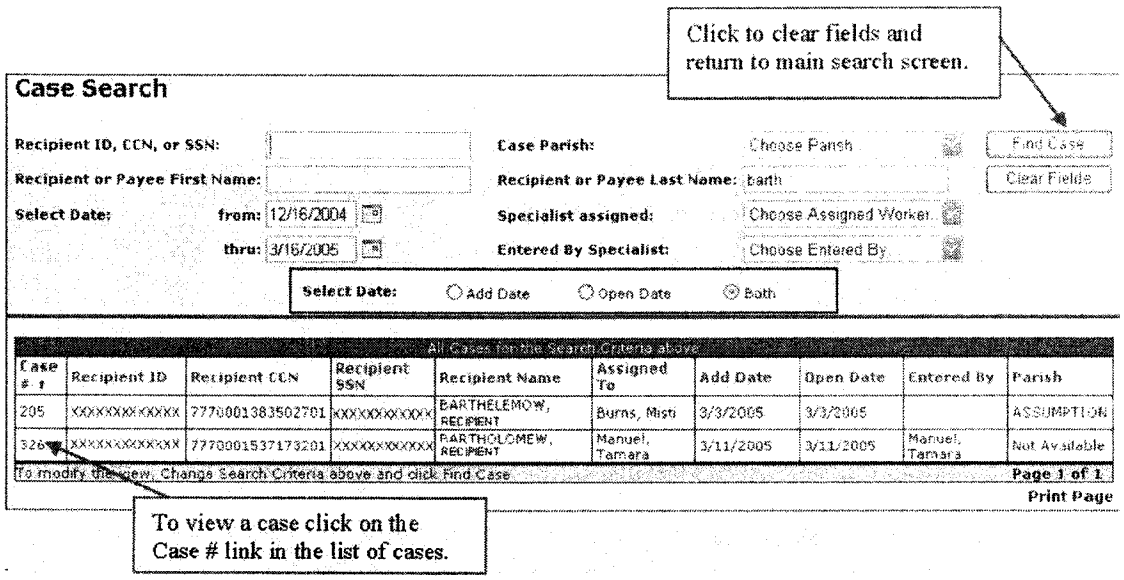
6.3 Case Search

From the Navigation menu, expand **Search** and click on the dropdown **Case**.



The **Specialist Assigned** field defaults to the specialist that is signed in, and the **Date** fields default to the three previous months ending on the current day. There are no required fields.

To view all cases in the previous three months for any recipient with the last name Bartholomew, enter 'Barth' in the **Last Name** field and click the **Find Case** button.

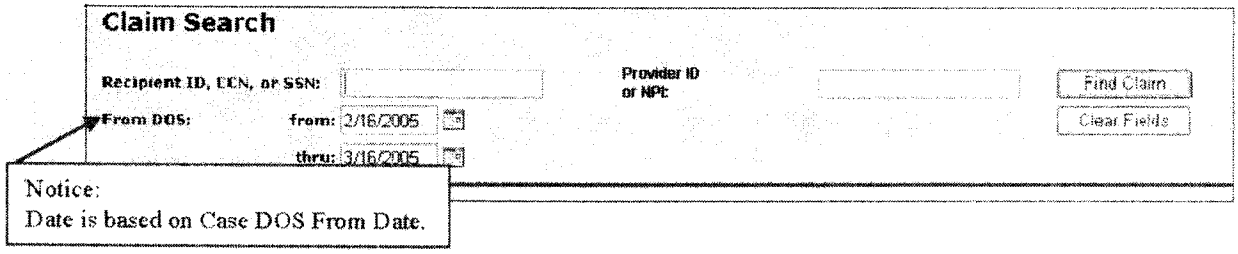


Note:

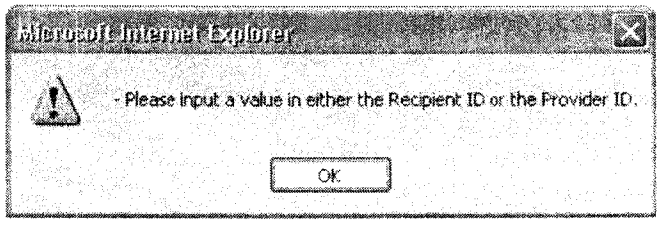
- *If you click on the **Case #** link on the Cases Screen, the search screen closes and the specified detail opens on the application main screen.*

6.4 Claims Search

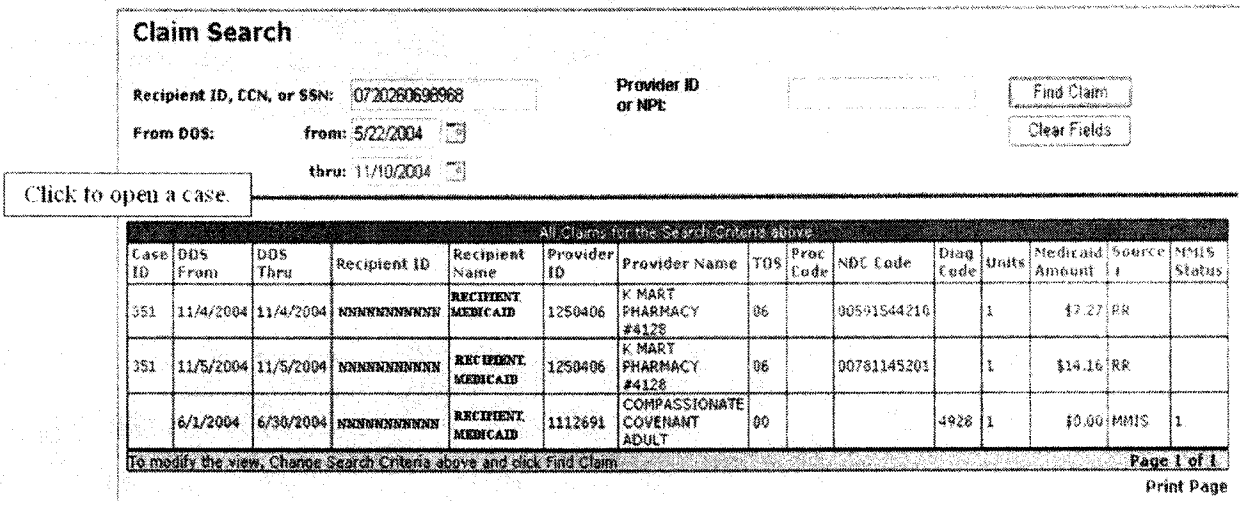
From the Navigation menu, expand **Search** and click on the dropdown **Claim**.



The date fields default to the previous month ending on the current day. Either a Recipient ID or Provider ID is required to perform a search. If a user attempts to perform a search without at least one of these fields, the following reminder is provided:



To search for a group of claims associated with a particular provider, enter a provider ID and click **Find Claim**. Also available is the option to search for a group of claims for an individual recipient. Enter the Recipient ID, CCN, or SSN and click the **Find Claim** button. A list of all claims that meet all criteria entered is displayed beneath the search.

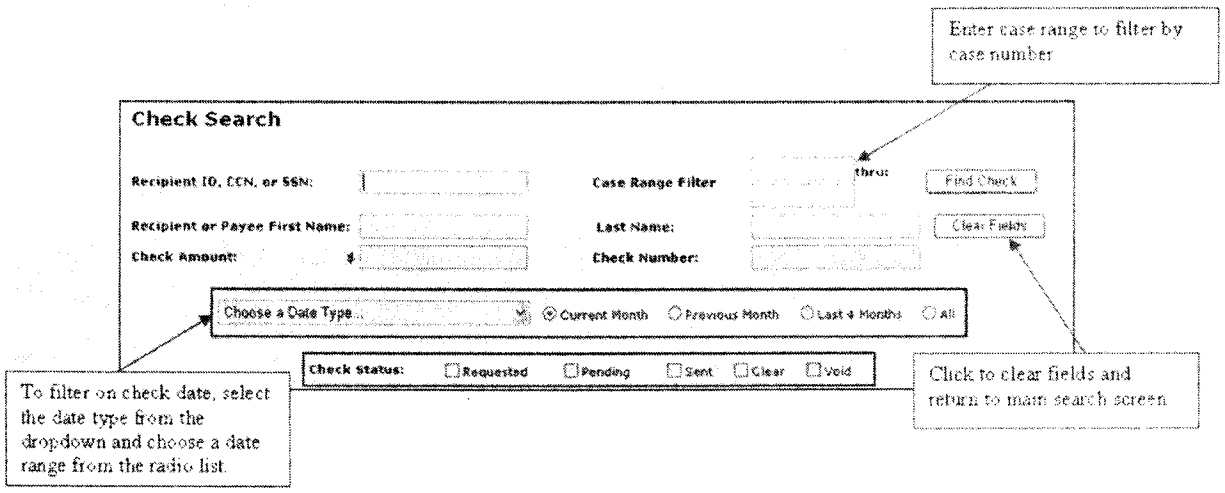


Notes:

- *Claims from both Recipient Reimbursement and MMIS will be returned in results if they meet criteria.*

6.5 Check Search

From the Navigation menu, expand **Search** and click on the dropdown **Check**.

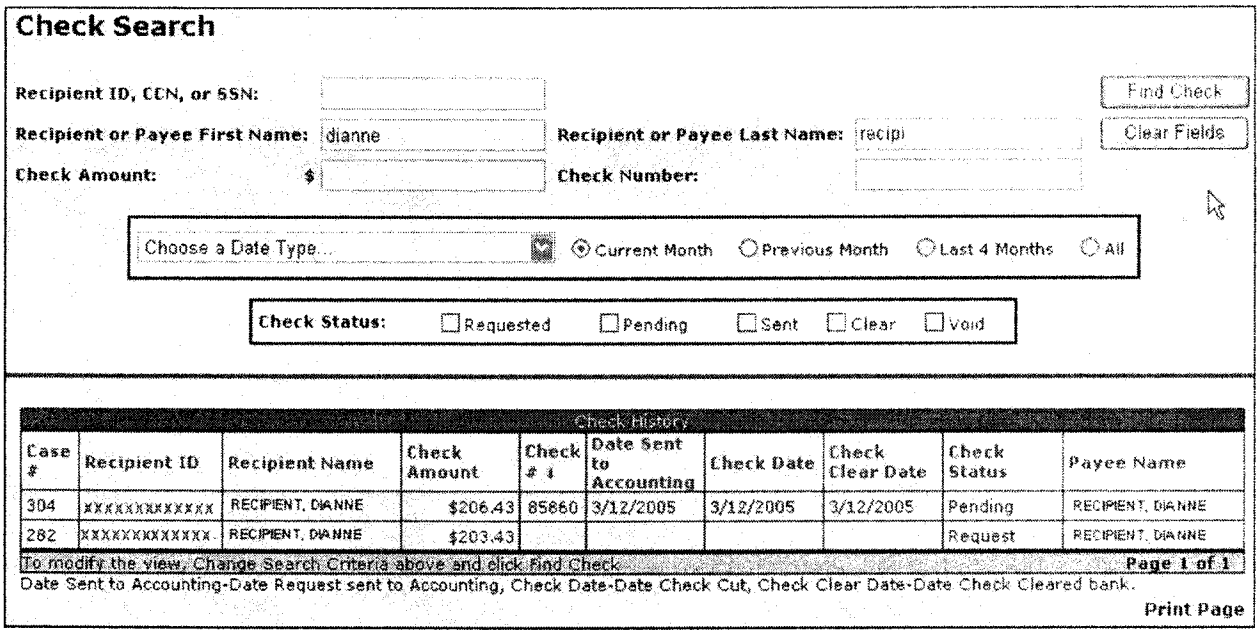


The Check Search screen is a list of all checks during the selected time period. You may use a variety of sort and filter methods to modify the view of the check list. The screen defaults to checks (of all statuses) requested in the current month.

The optional search criteria include:

Entry Fields: Recipient ID, CCN or SSN, check amount, check number, recipient or payee first and last name.
Date Type: Check date requested, check date effective, and check date cleared with the option to select one: Current, Previous Month, Last 4 Months, and All.
Check Status: Requested, Pending, Sent, Clear, Void

If a value is entered in the **Recipient or Payee First Name** or **Recipient or Payee Last Name** text boxes, the results will include all entries where Recipient or Payee First and Last Name match the value entered.

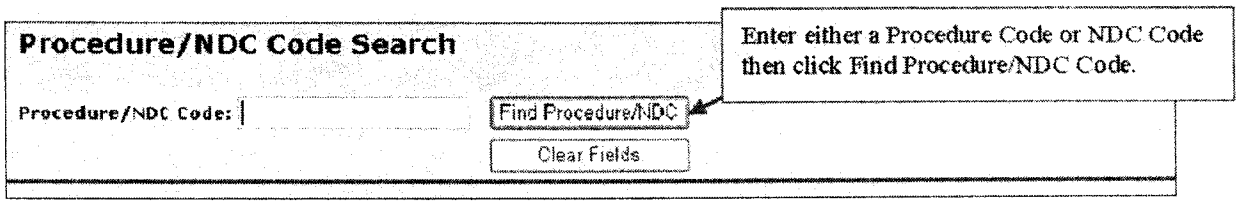


Note:

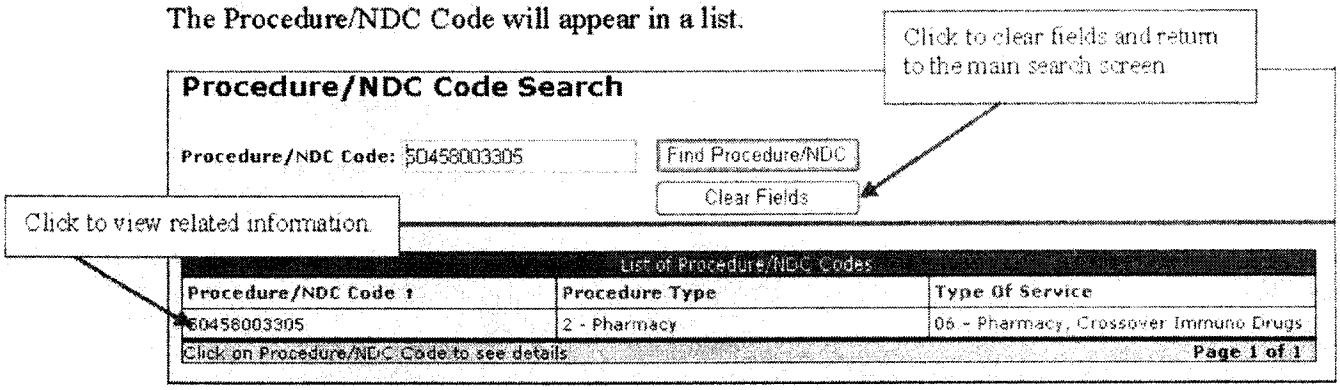
- *Only those checks which meet all of the specified search criteria are displayed.*

6.6 Procedure / NDC Code Search

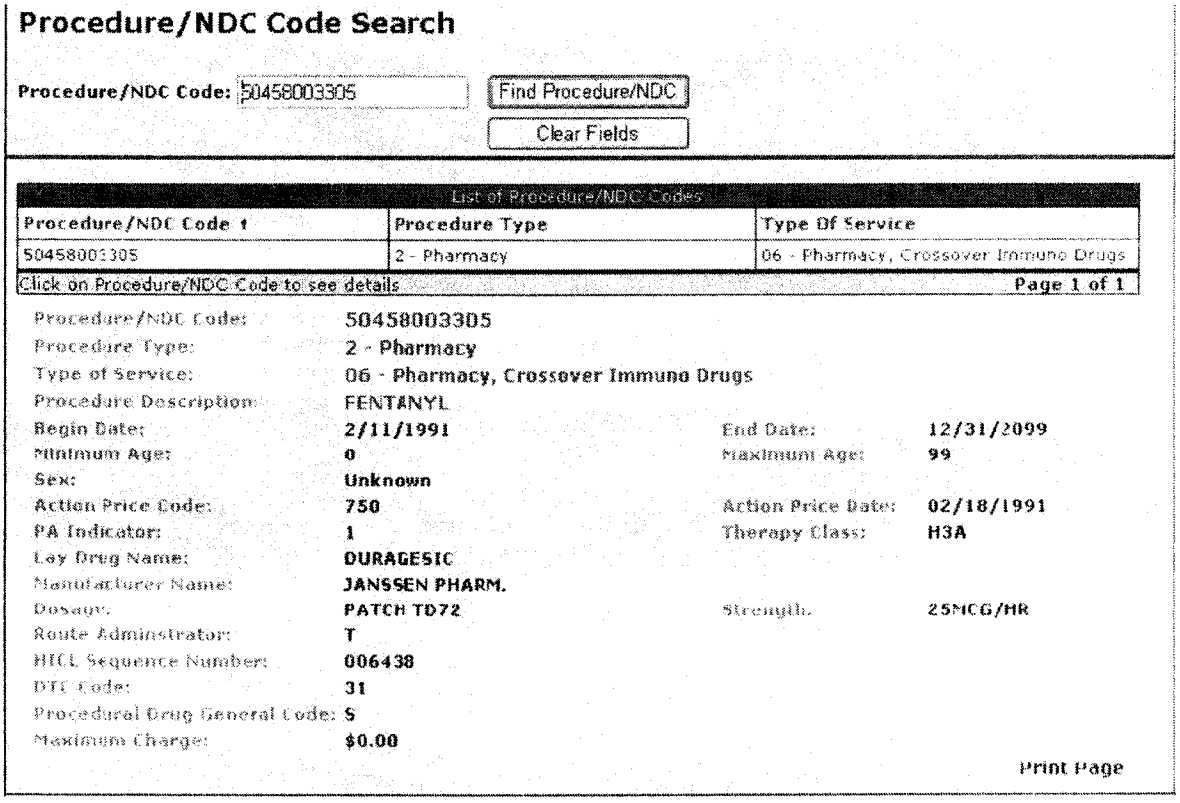
From the Navigation menu, expand **Search** and click on the dropdown **Procedure/NDC Code**.



The Procedure/NDC Code will appear in a list.

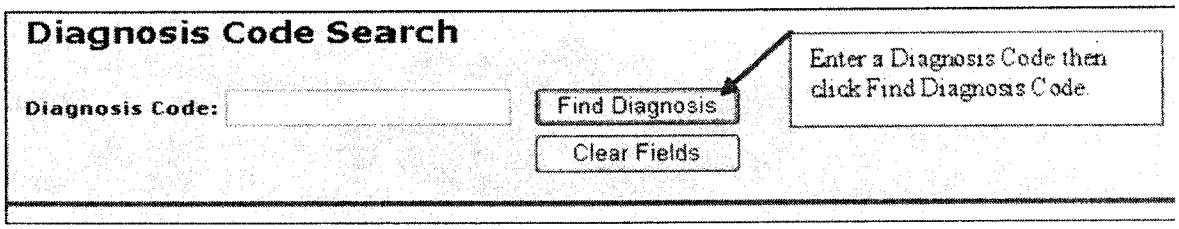


Click on a **Procedure/NDC Code** link from the list to view related information (type of service, maximum charge, and beginning and end dates):

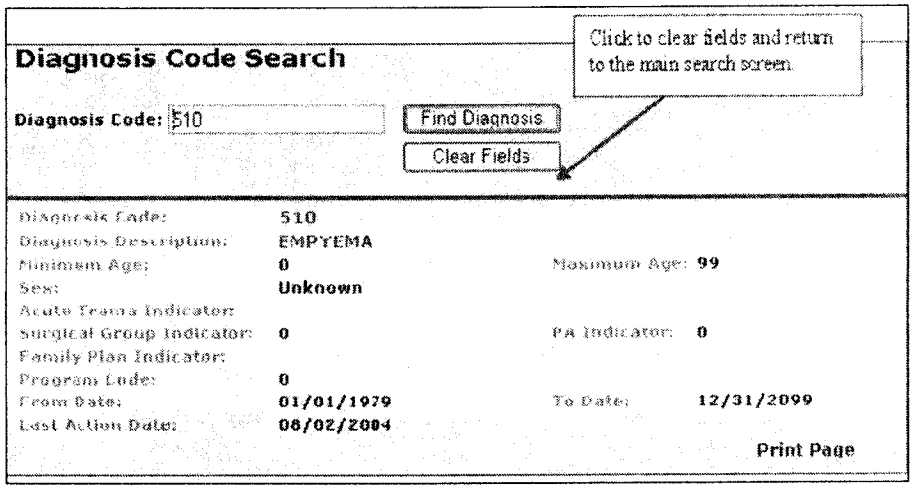


6.7 Diagnosis Code

From the Navigation menu, expand **Search** and click on the dropdown **Diagnosis Code**.



Enter a Diagnosis Code in the **Diagnosis Code** text box to view the Diagnosis Code information (such as description and maximum age):

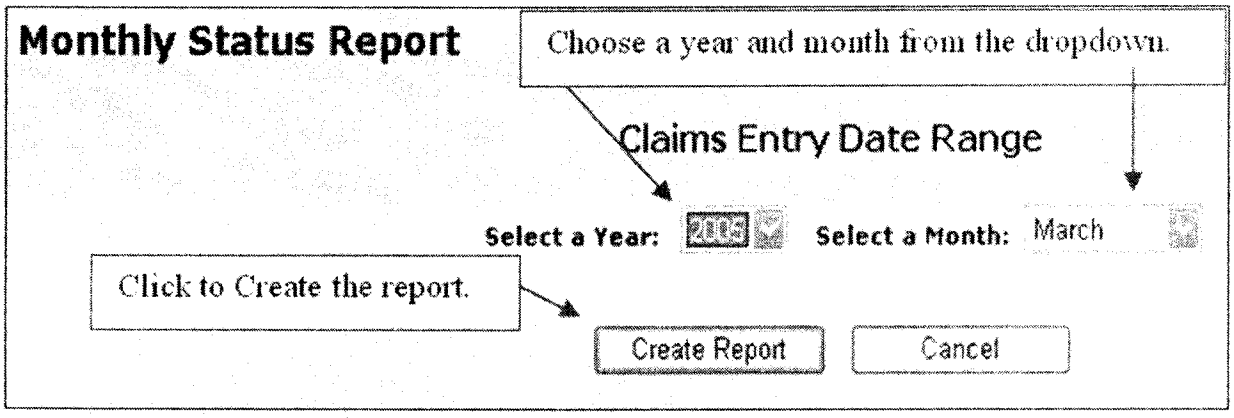


7.0 Reports

The following reports are available for both Program Specialist and Administrative user roles. Users are enabled to specify the basic parameters of the reports. Once the parameters for the report are entered, the user clicks on the **Create Report** button. The report opens in PDF format for printing or view. A **Cancel** button is provided to enable the user to cancel the report generation process and return to the Queue screen.

7.1 Monthly Status

The Monthly Status report provides count and amount details for a single calendar month.

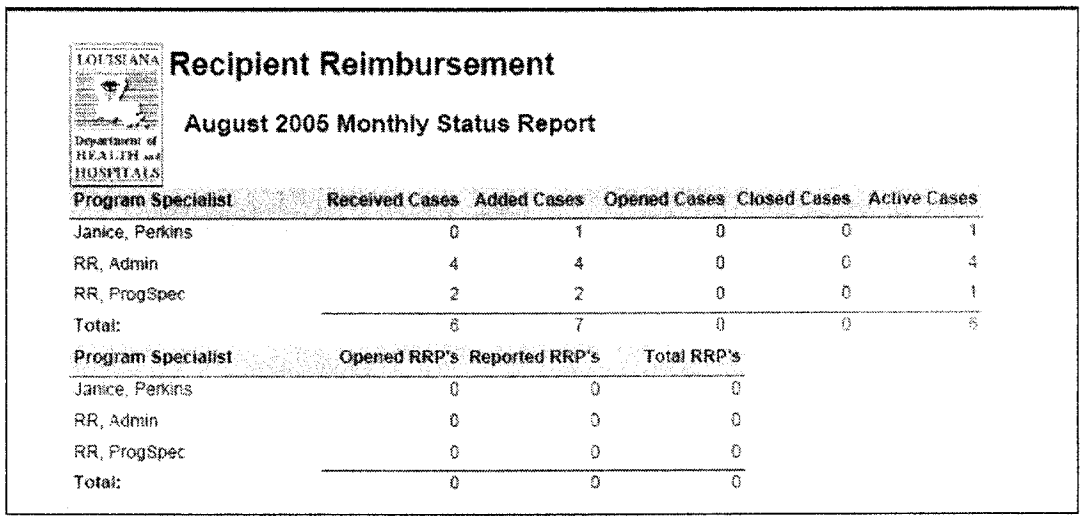


The first part of the report includes the counts summed per Program Specialist. The report is sorted by program specialist.

Newly Created– a count of added cases entered in the system within the month.
Total Closed – a count of cases that were closed within the month regardless of case creation date.
Total Active – a count of cases that are were not closed as of the last day of the month regardless of case creation date.

The second section of the report is focused on Amounts and includes only cases that were created during the month being reported. Total amounts are then further broken down to claim type (either Professional or Pharmaceutical).

Requested – Includes a sum of all requested Billed_Amount for all claims entered during the month.
Paid – Includes a sum of the Reimbursement_Amount for claims marked to be paid for all cases closed by the end of the reporting month and created within the reported month.
Still Active – Includes a sum of Billed_Amount for cases created within the month but not closed.
Not Covered – Is the remainder of the amounts above as calculated by the following formula: *(Requested – Paid – Still Active) = Not Covered*



Recipient Reimbursement

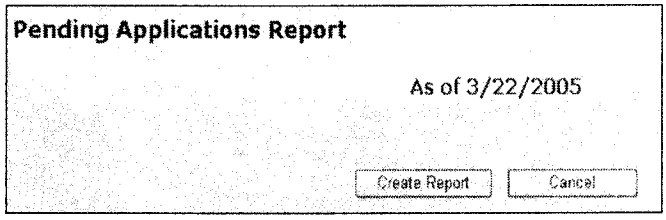
August 2005 Monthly Status Report

Program Specialist	Received Cases	Added Cases	Opened Cases	Closed Cases	Active Cases
Janice, Perkins	0	1	0	0	1
RR, Admin	4	4	0	0	4
RR, ProgSpec	2	2	0	0	1
Total:	6	7	0	0	6

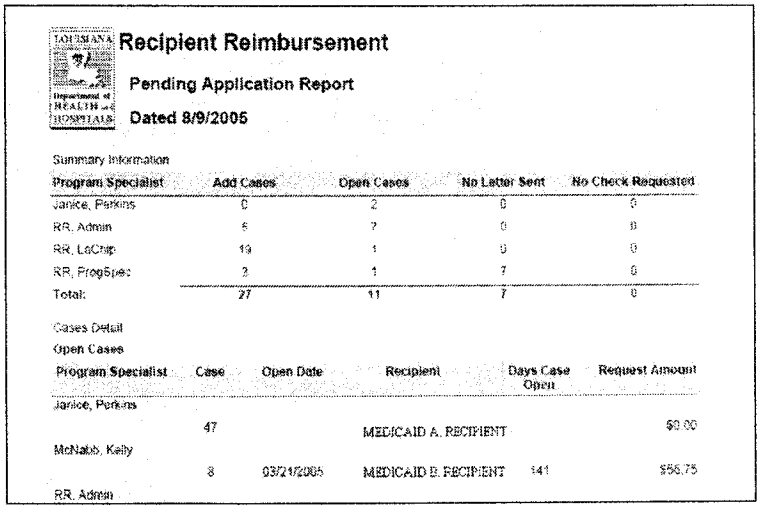
Program Specialist	Opened RRP's	Reported RRP's	Total RRP's
Janice, Perkins	0	0	0
RR, Admin	0	0	0
RR, ProgSpec	0	0	0
Total:	0	0	0

7.2 Pending Application

The Pending Application Report displays cases that are pending action at the time the report is generated. Cases that are pending action include open cases, closed cases for which letters have not been printed, and closed cases checks have not been requested.



Cases that are pending application are summarized in the report by action pending and Program Specialist. The detail of each case that is pending action is grouped by the type of action pending. The report is sorted by program specialist. The report also includes a list of all cases that have been open over the average turnaround time, oldest case first.



Recipient Reimbursement

Pending Application Report

Dated 8/9/2005

Summary Information

Program Specialist	Add Cases	Open Cases	No Letter Sent	No Check Requested
Janice, Perkins	0	2	0	0
RR, Admin	6	7	0	0
RR, LaChip	19	1	0	0
RR, ProgSpec	2	1	7	0
Total:	27	11	7	0

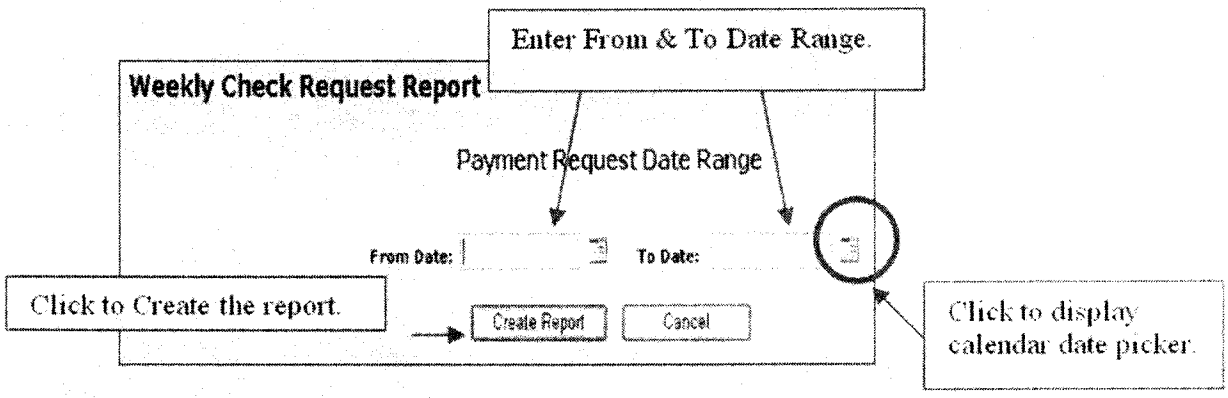
Cases Detail

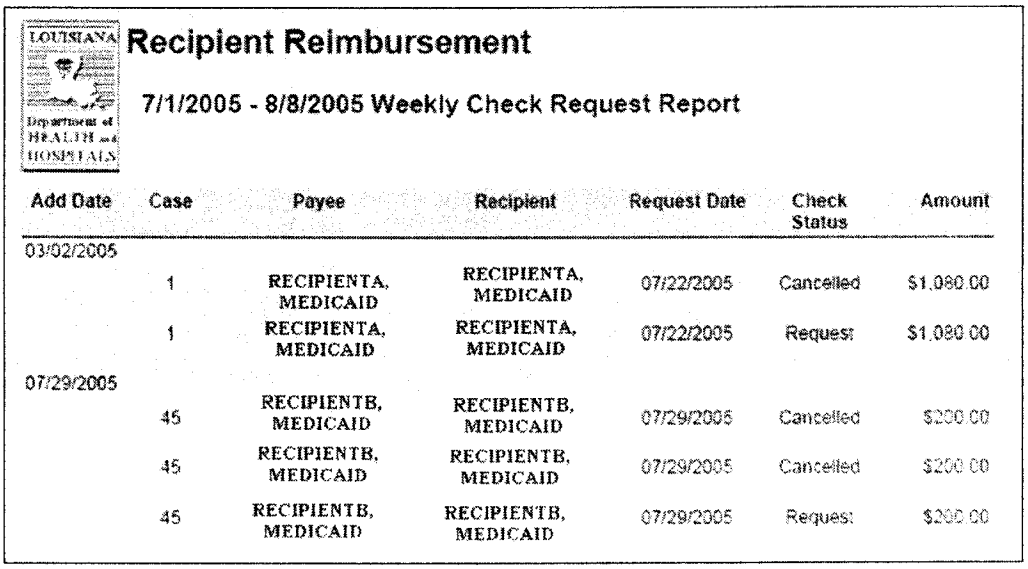
Open Cases

Program Specialist	Case	Open Date	Recipient	Days Case Open	Request Amount
Janice, Perkins					
	47		MEDICAID A. RECIPIENT		$0.00
McNabb, Kelly					
	8	03/21/2005	MEDICAID B. RECIPIENT	141	$56.75
RR, Admin					

7.3 Weekly Check Request

The weekly check request report lists checks that have been requested during the weekly check batch process.





LOUISIANA Department of HEALTH and HOSPITALS

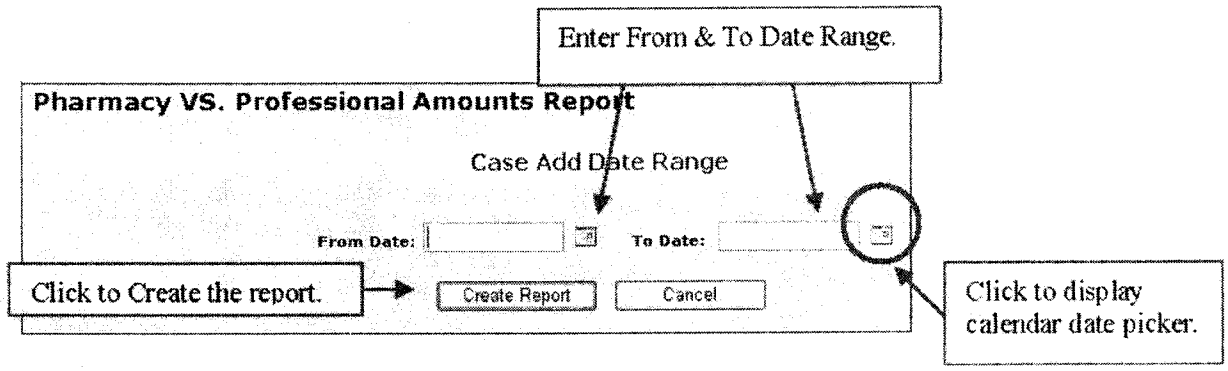
Recipient Reimbursement

7/1/2005 - 8/8/2005 Weekly Check Request Report

Add Date	Case	Payee	Recipient	Request Date	Check Status	Amount
03/02/2005						
	1	RECIPIENTA, MEDICAID	RECIPIENTA, MEDICAID	07/22/2005	Cancelled	$1,080.00
	1	RECIPIENTA, MEDICAID	RECIPIENTA, MEDICAID	07/22/2005	Request	$1,080.00
07/29/2005						
	45	RECIPIENTB, MEDICAID	RECIPIENTB, MEDICAID	07/29/2005	Cancelled	$200.00
	45	RECIPIENTB, MEDICAID	RECIPIENTB, MEDICAID	07/29/2005	Cancelled	$200.00
	45	RECIPIENTB, MEDICAID	RECIPIENTB, MEDICAID	07/29/2005	Request	$200.00

7.4 Pharmacy vs. Professional Amount

The Pharmacy vs. Professional Amount report compares pharmaceutical versus professional amounts paid according to a date range that you specify.



The report includes only cases which have a closed status, meaning that the case claim(s) eligibility and amount paid have been finalized regardless of whether or not the recipient has cashed the check.

Recipient Reimbursement

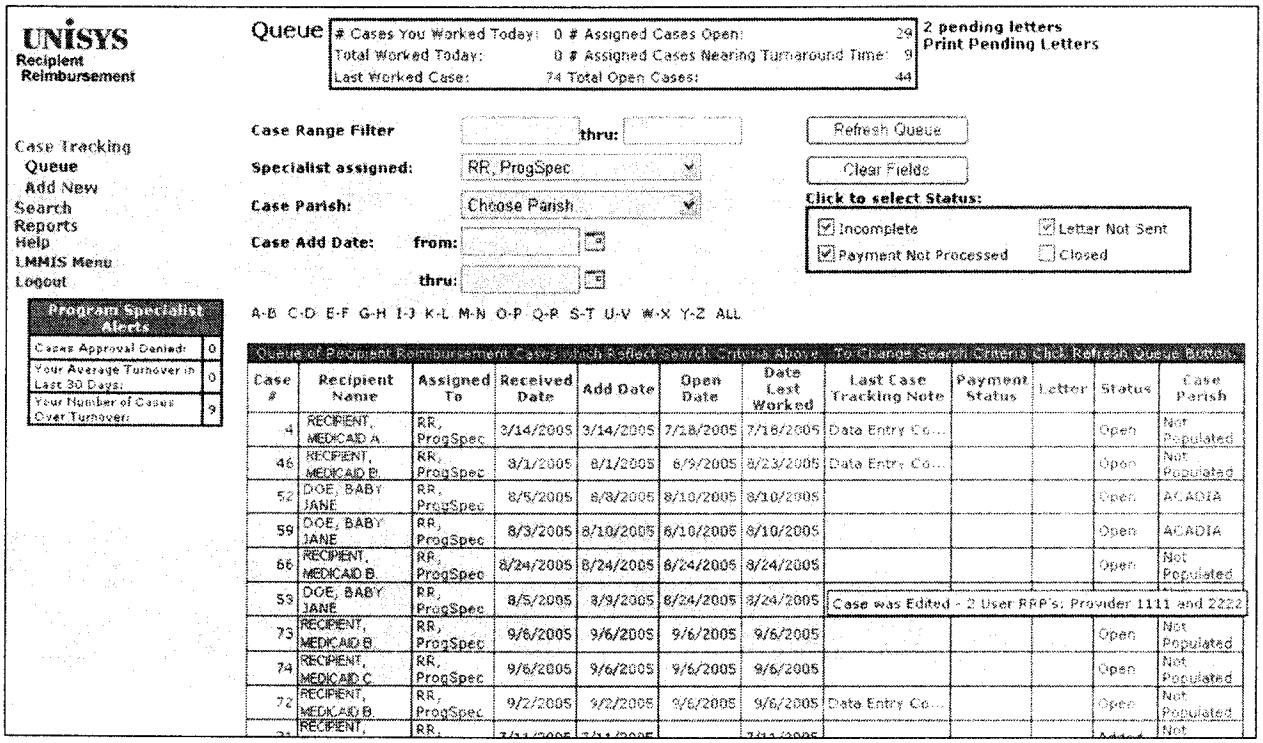
Pharmacy vs. Professional Report

Closed Cases Entered from 3/15/2005 - 3/25/2005

Add Date	Case	Payee	Recipient	Pharmacy	Professional
03/18/2006					
	350	RECIPA, MEDICAID	RECIPA, MEDICAID	$175.51	$0.00
	351	RECIPB, MEDICAID	RECIPB, MEDICAID	$568.60	$0.00
	353	RECIPC, MEDICAID	RECIPC, MEDICAID	$11.38	$0.00
	355	RECIPD, MEDICAID	RECIPD, MEDICAID	$0.00	$40.00
03/21/2006					
	357	RECIPE, MEDICAID	RECIPE, MEDICAID	$13.48	$0.00
	361	RECIPF, MEDICAID	RECIPF, MEDICAID	$0.00	$3.55
	362	RECIPG, MEDICAID	RECIPG, MEDICAID	$19.68	$0.00
			Totals:	$788.08	$43.55

8.0 Administrator

Admin users are provided with privileges which enable them to perform all tasks. In addition, an Admin Queue option permits them to view a list of cases which require Administrative Approval.



Administration – click to expand the dropdown Admin menu items

- **Queue** – Admin Queue of Recipient Cases that require Admin Approval
- **Assignment Queue** – Opens a queue that the administrator may use to reassign cases and change case status back to open.
- **Configuration** – Opens a screen that allows the administrator to modify configurable values in the application.
- **Payment Configuration** – Allows Admin to set new values for variables used to calculate payment amounts.
- **Reports** – click to expand dropdown Admin Report menu
  - Statistical Case Amount Paid vs. Requested by Date Range
  - No. Cases & Amount of Request by Date Range
  - Average Turnaround Time
  - Average Work Time

Administrative Alerts

- **Cases Require Approval** – A count of all cases in the Administrative Queue.
- **Group Average Turnover in Last 30 days** – Average of number of days that every case which has closed in the last 30 days was open.
- **Group Number of cases over Turnover** – Number of cases for the group that are currently over the Configured Turnover Limit.

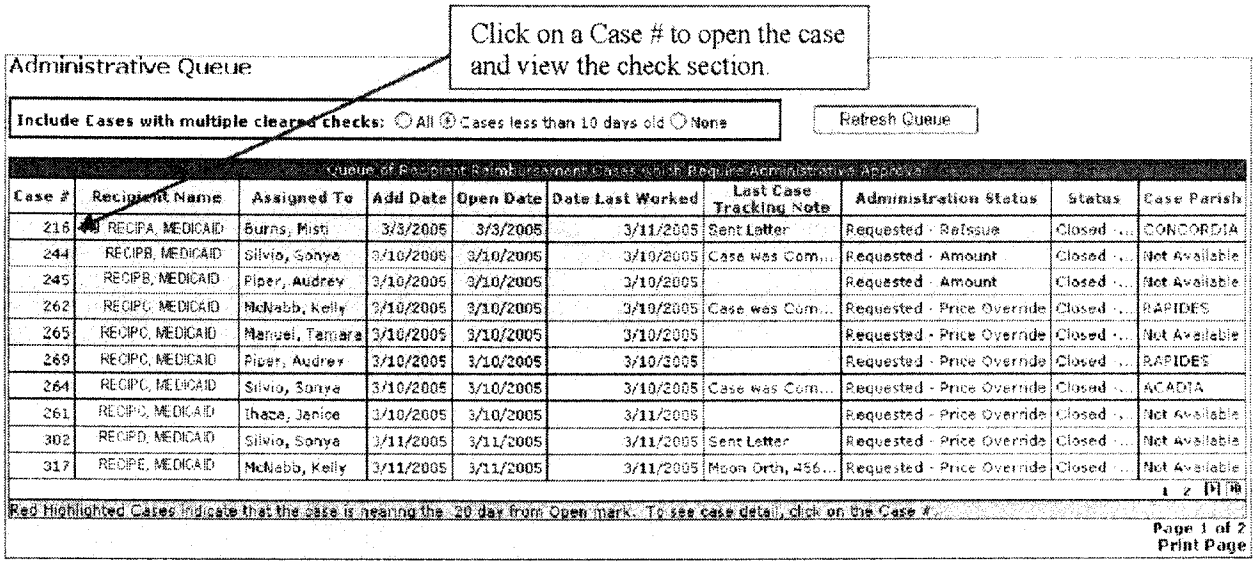
Statistics

- **# Cases you worked today** – Number of cases user logged in has worked today.
- **Total worked today** – Number of cases all users have worked today.
- **Last worked Case** – Links to the case last worked by Specialist logged in.
- **# Assigned Cases open** – Number of Cases assigned to the user logged in and that are currently in open status.
- **# Assigned Cases nearing Turnaround Time** – Number of open cases the user has assigned to them and been in the system over the configurable turnaround time alert.
- **# Total open Cases** – Number of open cases in the system for all users.

8.1 Queue

Upon login as an Administrator, the Administration Queue is displayed (alternatively, you can get to the queue from the Navigation menu by expanding Administration and clicking on the dropdown Queue).

The Queue lists all cases for which checks have been requested and that require administrative approval.

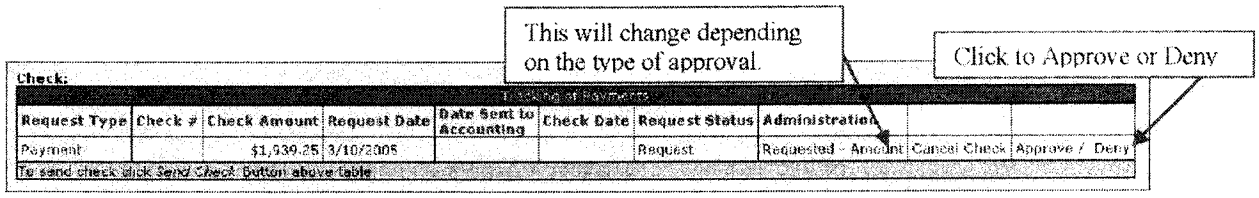


Case #	Recipient Name	Assigned To	Add Date	Open Date	Date Last Worked	Last Case Tracking Note	Administration Status	Status	Case Parish
216	RECIPA, MEDICAID	Burns, Misti	3/3/2005	3/3/2005	3/11/2005	Sent Letter	Requested - Reissue	Closed -...	CONCORDIA
244	RECIPB, MEDICAID	Silvio, Sonya	3/10/2005	3/10/2005	3/10/2005	Case was Com...	Requested - Amount	Closed -...	Not Available
245	RECIPB, MEDICAID	Piper, Audrey	3/10/2005	3/10/2005	3/10/2005		Requested - Amount	Closed -...	Not Available
262	RECIPC, MEDICAID	McNabb, Kelly	3/10/2005	3/10/2005	3/10/2005	Case was Com...	Requested - Price Override	Closed -...	RAPIDES
265	RECIPC, MEDICAID	Manuel, Tamara	3/10/2005	3/10/2005	3/10/2005		Requested - Price Override	Closed -...	Not Available
269	RECIPC, MEDICAID	Piper, Audrey	3/10/2005	3/10/2005	3/10/2005		Requested - Price Override	Closed -...	RAPIDES
264	RECIPC, MEDICAID	Silvio, Sonya	3/10/2005	3/10/2005	3/10/2005	Case was Com...	Requested - Price Override	Closed -...	ACADIA
261	RECIPC, MEDICAID	Ihaze, Janice	3/10/2005	3/10/2005	3/11/2005		Requested - Price Override	Closed -...	Not Available
302	RECIPD, MEDICAID	Silvio, Sonya	3/11/2005	3/11/2005	3/11/2005	Sent Letter	Requested - Price Override	Closed -...	Not Available
317	RECIPE, MEDICAID	McNabb, Kelly	3/11/2005	3/11/2005	3/11/2005	Mpon Orth, 456...	Requested - Price Override	Closed -...	Not Available

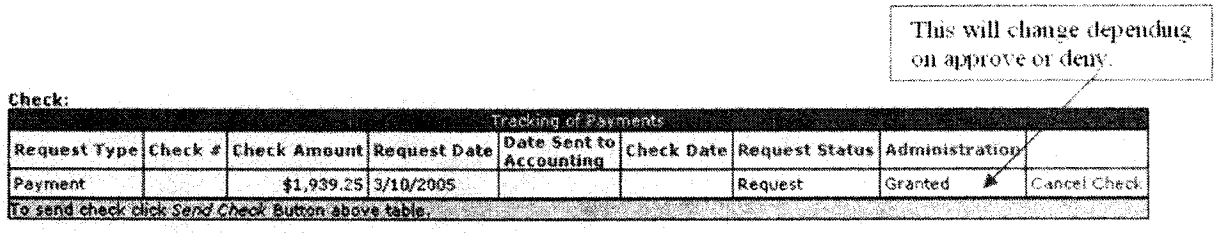
A check requires administrative approval if:

- A **price override** is present.
- A **check amount** is over the maximum amount (the administrative configurable amount)
- A sent check has been voided and **reissued**.

Click on a case number to begin the administrative approval process. Click on the **Approve** link or the **Deny** link.

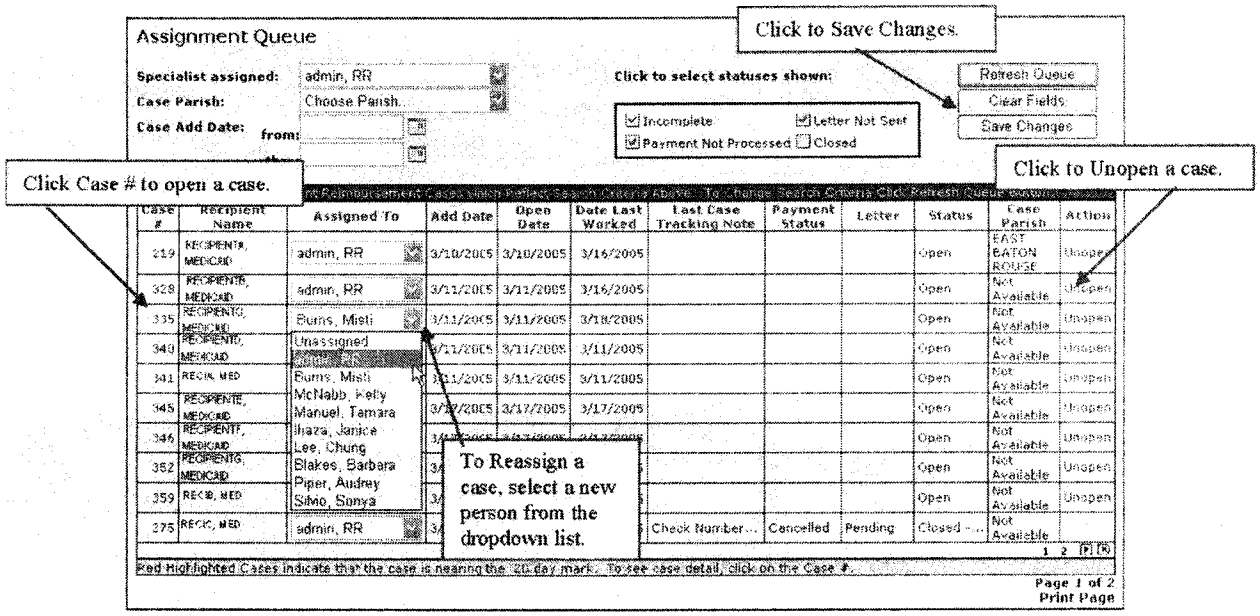


The administrative approval decision is displayed:



8.2 Assignment Queue

From the Navigation menu, expand **Administration** and click on the dropdown **Assignment Queue**. Use filters at the top of the queue to modify the cases that are displayed in the queue.



Remember to save changes before leaving the screen by clicking the **Save Changes** button at top right.

335	RECIPIENT, MEDICAID	admin, RR	3/11/2005	3/11/2005	3/18/2005				Open	Not Available	Unopen

To Unopen a case:
All open cases are provided with an **Unopen** link in the last column of the queue on the line that displays the case to be unopened.

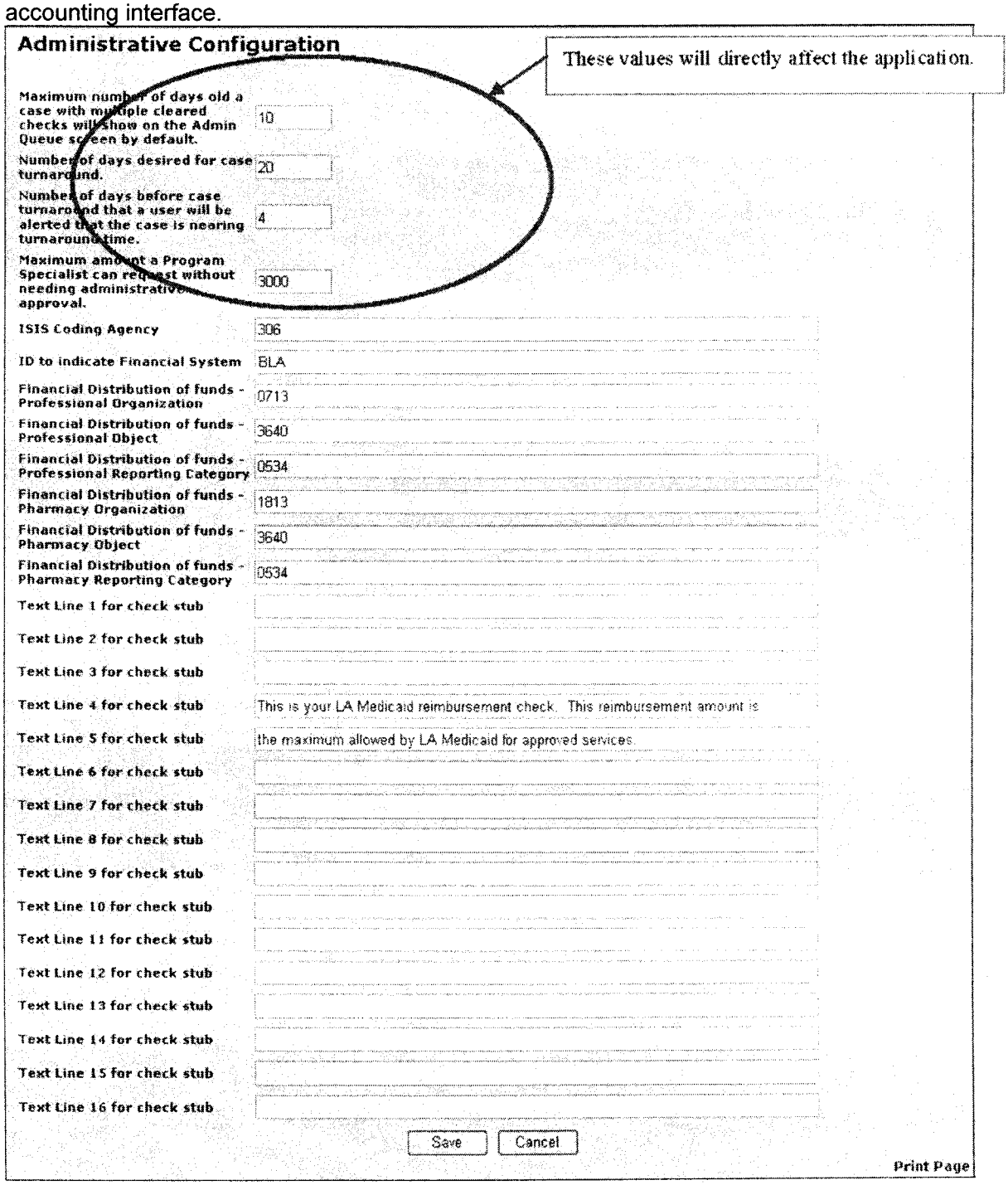
Click the **Unopen** link on the line that displays the case. Additional notes open.

335	RECIPIENT, MEDICAID	admin, RR	3/11/2005		3/22/2005	Un-opened Case			Added	Not Available	

The case status is now changed to 'Added' and the **Unopen** link is removed.

8.3 Configuration

From the Navigation menu, expand **Administration** and click on the dropdown **Configuration**. The top four Configuration values affect the application. The other configuration values are for the accounting interface.



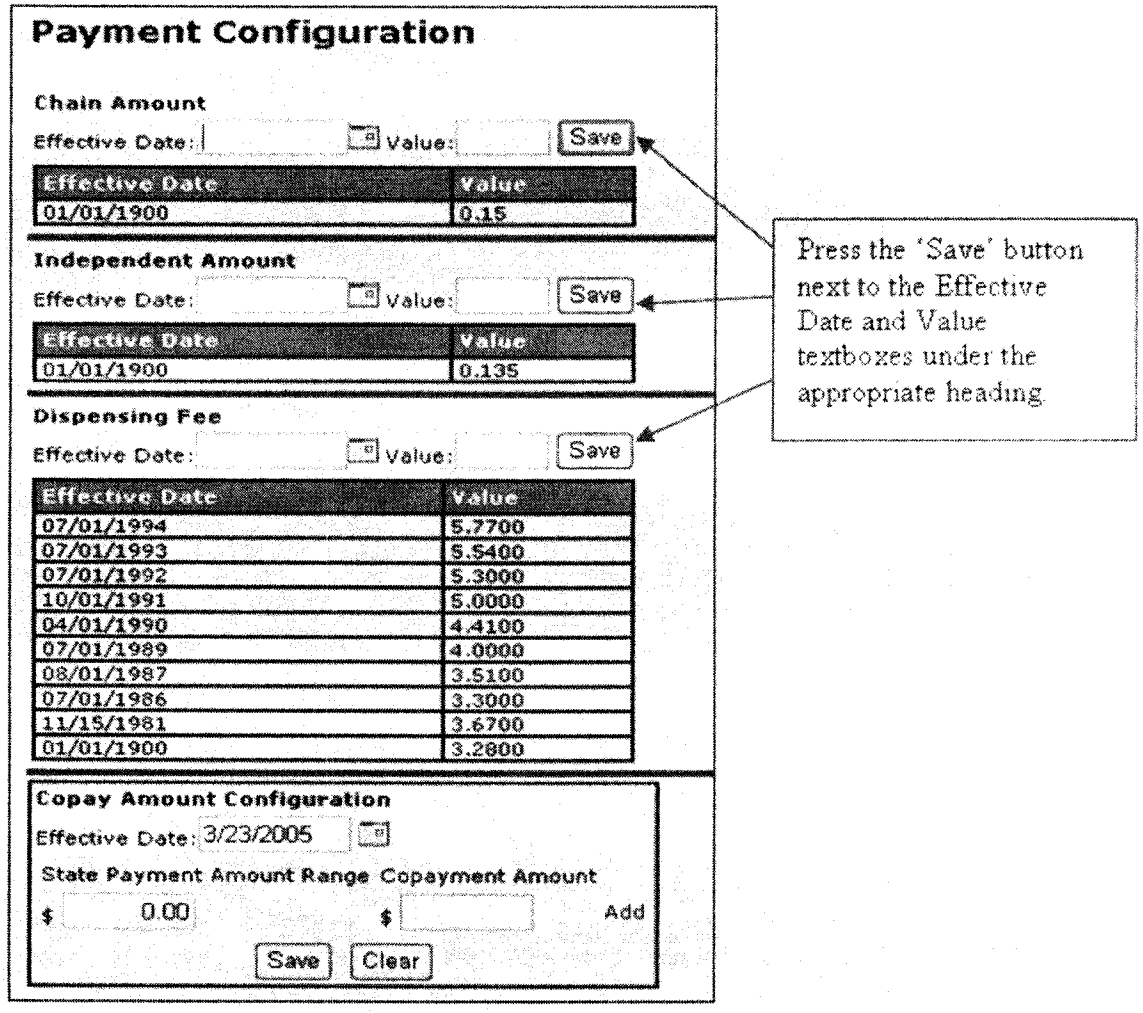
To change the Configuration Value:

Make the change in the textbox corresponding to the label of the value to be changed.

Click the **Save** button.

8.4 Payment Configuration

From the Navigation menu, expand **Administration** and click on the dropdown **Payment Configuration**. These values affect the pharmacy pricing of the application.



To change the Chain Amount, Independent Amount, or Dispensing Fee:

- Enter the Effective Date and Value in the textboxes under the appropriate heading.
- Click the **Save** button.

To change Co-pay Amount Configuration:

- Enter Effective Date, Minimum Dollar Range, and Co-pay in the textboxes under the Co-pay Amount Configuration heading.
- Click the **Save** button under the Co-pay Amount Configuration heading.

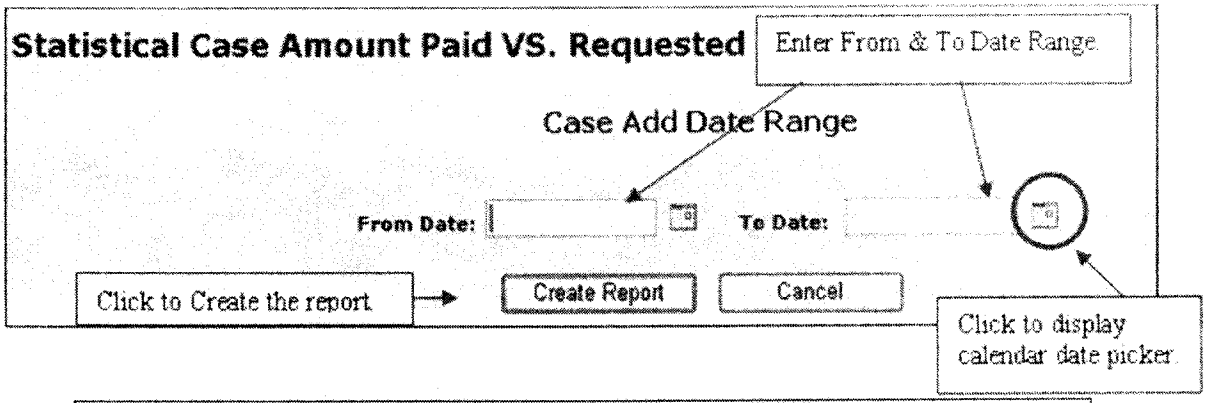
8.5 Administrative Reports

From the Navigation menu, expand **Administration** and click to expand **Reports**.

The Administrative Reports dropdown contains another dropdown menu that includes additional reports only for administrators.

8.5.1 Statistical Case Amount Paid vs. Request

The Statistical Case Amount Paid vs. Request report compares amount paid versus amount requested per case according to a specified date range. The report includes only cases which have a closed status, meaning that the case claim(s) eligibility and amount paid have been finalized regardless of whether or not the recipient has cashed the check.



Recipient Reimbursement

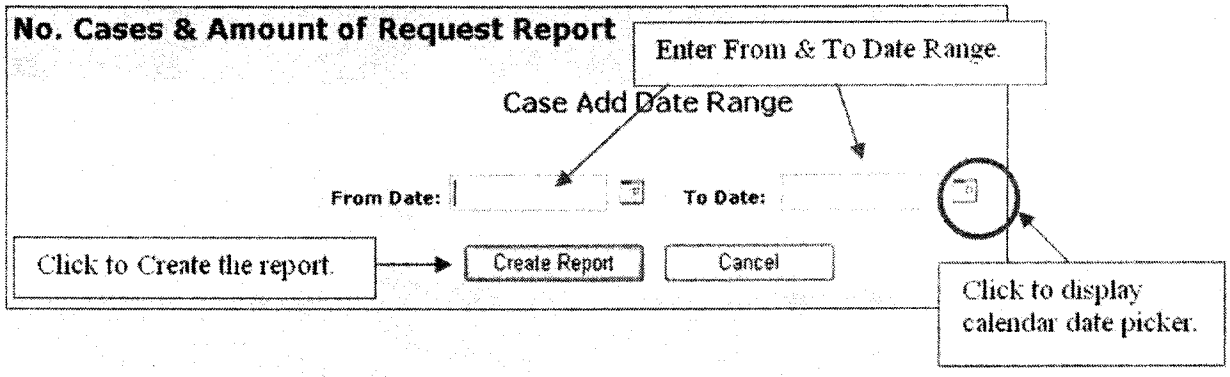
Paid Amount vs. Requested Amount Report

Closed Cases Entered from 3/15/2005 - 3/25/2005

Add Date	Case #	Payee	Recipient	Requested	Paid	Difference
03/15/2005						
	350	BASS, KRISTE	BASS, KRISTE	$158.69	$115.91	$42.68
	351	BABINEAUX, MYRNA	BABINEAUX, MYRNA	$624.20	$596.60	$27.60
	353	HOBBS, JAYSON	HOBBS, JAYSON	$56.90	$11.39	$45.51
	355	LANDRY, MARY	LANDRY, MARY	$40.00	$40.00	$0.00
03/21/2005						
	357	ELMORE, MILDRED	ELMORE, MILDRED	$19.70	$13.48	$6.22
	361	HILL, BRANDY	HILL, BRANDY	$20.00	$3.55	$16.45
	362	DAVIS, LADONNA	DAVIS, LADONNA	$58.84	$19.68	$39.16
			Totals:	$978.33	$800.51	$177.82

8.5.2 No. Cases & Amount of Request

The No. Cases & Amount of Request report sums up the number of newly opened cases and the amount requested per Program Specialist for each date within the specified date range. Program Specialist is determined by the individual assigned to the case in the application.



Recipient Reimbursement

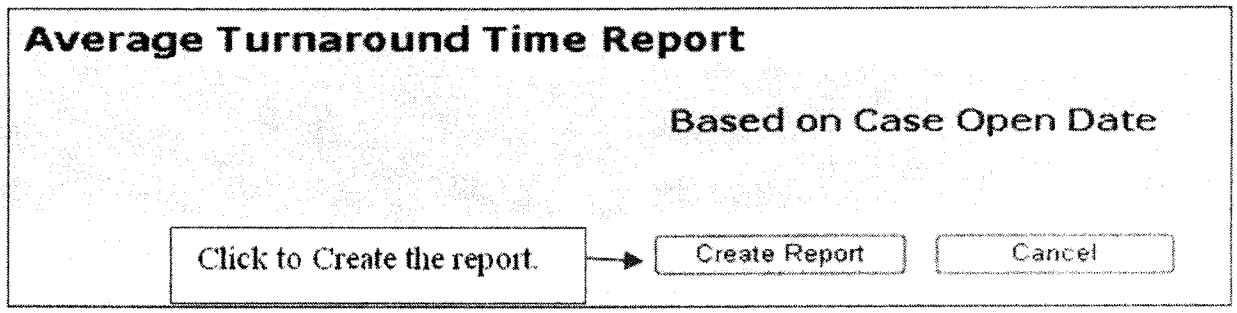
Daily Number of Cases with Requested Amounts

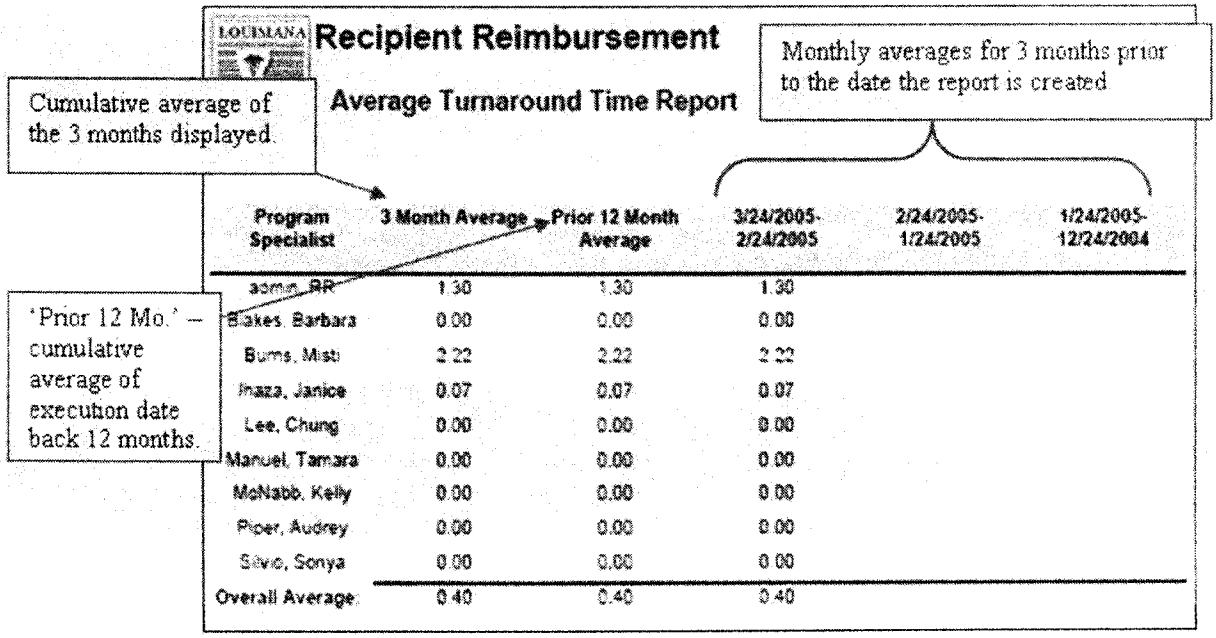
Cases Entered from 7/1/2005 - 8/8/2005

Add Date	Assigned To	# Opened	Amount Requested
07/01/2005			
	Buckley, J.	3	$230.44
	COLLINS, D	4	$423.15
	Davis, D.	7	$2,988.52
	Manuel, Tamara	5	$2,499.72
07/05/2005			
	Buckley, J.	3	$550.95
	COLLINS, D	1	$329.64
	Ihaza, Janice	2	$437.57
	Manuel, Tamara	1	$360.00
	McNabb, Kelly	1	$142.00
07/06/2005			
	Buckley, J.	4	$404.27
	COLLINS, D	3	$326.46
	Davis, D.	11	$3,090.18

8.5.3 Average Turnaround Time

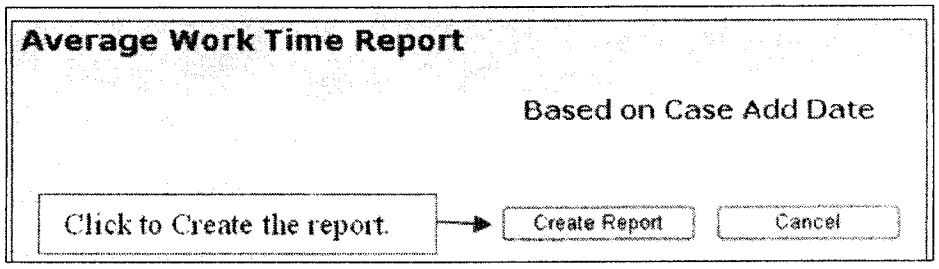
The Average Turnaround Time report averages the number of days that it takes to close a case by calculating the period between the date a case was initially worked by the assigned Specialist (Case Date) and the date on which the case was either denied or the case was closed such that the check has been cut and letters printed. Cancelled cases are not included in the calculation for the average turnaround time.

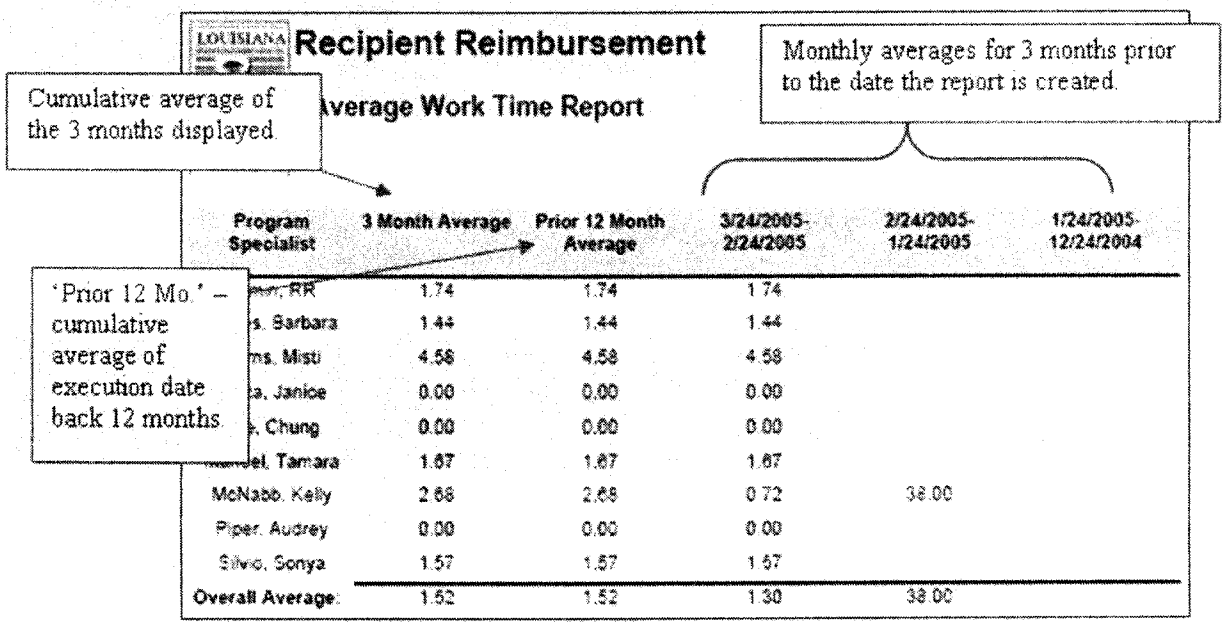




8.5.4 Average Work Time Report

This report will average the number of days that cases were worked, calculating from the date a case was initially input into the Recipient Reimbursement intranet application (Add Date) to the date the case was worked by the assigned Specialist (Open Date). Cases that have not been worked are calculated from Entry Date to Current date. Cancelled cases are not included in the calculation for the average work time.





9.0 Timeouts

9.1 Search Screen Timeouts

If you enter search criteria that are too broad, the system may time out. In that event, the following alert is displayed:

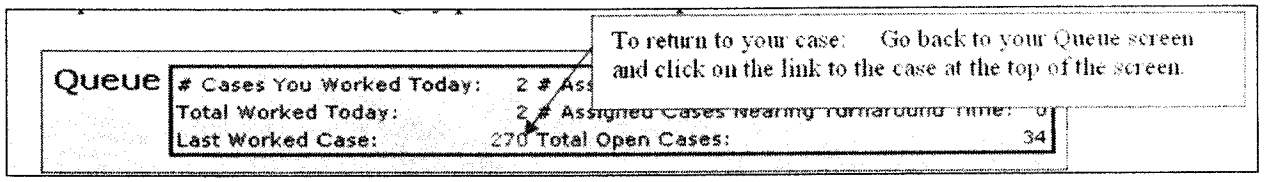
Refine your search by narrowing the criteria and try again.

9.2 Session Timeouts

Due to the volume of claims when performing edits for pricing or claim validity or duplicate claims, it is possible for the application to timeout when saving claims.

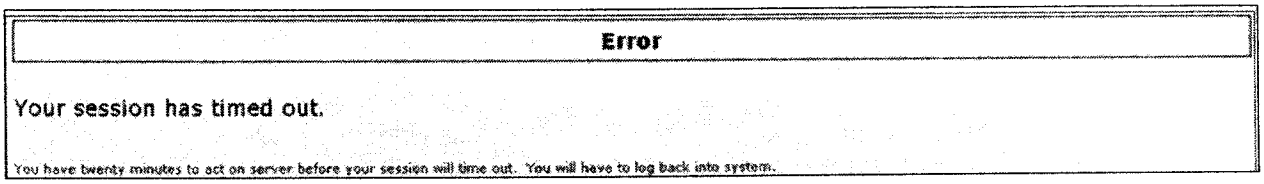
Actions to prevent a timeout:

- Save a case as often as possible. If you need to research a claim before entering a new record do a save.
- If you have not received an error message yet, but know that you have left the case open and inactive a lengthy period of time, reopen the case.



In the event that a timeout occurs:

- An alert similar to the one shown below will be displayed.
- Do NOT use the Internet Explorer **Back** button.
- Close the application in the internet browser window and reopen it.



10.0 Logout

To logout of the application, click **Logout** from the Navigation menu to return to the LMMIS File Transaction menu. Any time you close all open internet browser instances, you are required to login again.